



STANDARD OUT-PATIENT LABORATORY REQUISITION FOR MATERNITY CARE

ORDERING PRACTITIONER: ADDRESS, MSP PRACTITIONER NUMBER

Yellow highlighted fields must be completed to avoid delays in specimen collection and patient processing.

For tests indicated with a blue tick box [ ], consult provincial guidelines and protocols (www.BCGuidelines.ca)

Bill to -> [ ] MSP [ ] ICBC [ ] WorkSafeBC [ ] PATIENT [ ] OTHER:

PERSONAL HEALTH NUMBER (PHN) ICBC/WorkSafeBC NUMBER LOCUM FOR: PRACTITIONER NAME/MSP PRACTITIONER NUMBER:

LAST NAME OF PATIENT FIRST NAME OF PATIENT ORDER PRACTITIONER NAME/MSP PRACTITIONER NUMBER:

DOB YYYY MM DD SEX [ ] M [ ] F Fasting? \_\_\_\_\_ h pc If this is a STAT order please provide contact telephone number:

PRIMARY CONTACT NUMBER OF PATIENT SECONDARY CONTACT NUMBER OF PATIENT OTHER CONTACT NUMBER OF PATIENT Copy to Practitioner/MSP Practitioner Number/Address:

ADDRESS OF PATIENT CITY/TOWN PROVINCE

DIAGNOSIS ESTIMATED DATE OF CONFINEMENT (EDC) CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE ALLERGIES

TESTS PER THE PERINATAL SERVICES BC OBSTETRIC GUIDELINE

OTHER TESTS AS REQUIRED

SERUM INTEGRATED PRENATAL SCREEN (SIPS): Part 1 at 9 - 13+6 weeks Part 2 at 14 - 20+6 weeks QUAD SCREEN 14 - 20+6 WEEKS Maternal Serum AFP only Use separate requisitions for each screening test Complete Prenatal Genetic Screening Laboratory Requisition located at: http://www.perinatalservicesbc.ca/Documents/Screening/Prenatal-HCP/PrenatalBiochemistry-LabReq\_Fillable.pdf

0 - 14 WEEKS: RECOMMENDED TESTS Blood group and Antibody screen - Complete the BCY Prenatal Screening Request located on the CBS site at https://blood.ca/en/hospitals/bc-yukon-centre/test-request-forms Hematology profile (CBC) TSH (for those with risk factors for hypothyroidism) HIV Serology - complete the Serology Screening Requisition located at http://lmlabs.phsa.ca/health-professionals/test-requisitions (patient has legal right to choose not to have their name reported to public health = non-nominal reporting) Non-nominal reporting Syphilis Serology Hepatitis B (HBsAg) Hepatitis C (anti-HCV) (for women with risk factors) Rubella antibody titre (if first pregnancy) Chlamydia/Gonorrhea testing by NAAT Vaginal swab Cervical swab Urine Urine Midstream urine for C&S, list current antibiotics

24 - 28 WEEKS: RECOMMENDED TESTS Repeat Antibody screen in D negative (Rh negative) women or as indicated on previous CBS report. Use the BCY Prenatal Screening Request form located at on the CBS site at: https://blood.ca/en/hospitals/bc-yukon-centre/test-request-forms GTT - gestational diabetes screen (50g load, 1 h - post load) GTT - gestational diabetes confirmation (75 g load, 8-10 h fasting, water permitted, 2 h test)

35 - 37 WEEKS: RECOMMENDED TESTS Hematology profile (CBC) Group B Strep Screen Vagino-anorectal swab Penicillin allergy

SIGNATURE OF REQUESTING PRACTITIONER DATE SIGNED

CHEMISTRY Sodium Potassium Albumin Alk Phos ALT Bilirubin GGT Ferritin Uric Acid Creatinine Urine Protein/Creatinine Ratio Fasting glucose OR Hemoglobin A1C if risk factors for Type II diabetes Pregnancy test Urine Serum

VAGINITIS Initial (smear for Bacterial Vaginosis and yeast only) Chronic/recurrent (smear, culture, trichomonas) Trichomonas Testing

THYROID FUNCTION For physician referrals only. For other thyroid investigations, please order specific tests below and provide diagnosis. Monitor thyroid replacement therapy (TSH Only) Suspected Hypothyroidism (TSH first ± ft4) Suspected Hyperthyroidism (TSH first, ± ft4, ± ft3)

HEMATOLOGY Thalassemia/hemoglobinopathy investigation INR PTT Fibrinogen

URINE Midstream urine for C&S, list current antibiotics Macroscopic -> microscopic if dipstick positive Macroscopic -> urine culture if pyuria or nitrite present Macroscopic (dipstick) Microscopic Special case (if ordered together)

OTHER TESTS AND/OR PATIENT INSTRUCTIONS

IMMUNITY/PAST INFECTION Rubella antibody IgG Varicella serology (if no known Hx of disease or immunization) Parvovirus B19 IgG serology CMV IgG serology Toxoplasmosis IgG serology

ACUTE/NEW INFECTION ONLY Mumps serology (for post-exposure or with symptoms) Rubella IgM Parvovirus B19 IgM serology CMV IgM serology Toxoplasmosis IgM serology

DATE OF COLLECTION TIME OF COLLECTION PHLEBOTOMIST TELEPHONE REQUISITION RECEIVED BY (EMPLOYEE/DATE/TIME)

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.

