

Section 1 - Patient Information and Physician Information

| | | | |
|---|---|---|---|
| PERSONAL HEALTH NUMBER (or out-of province Health Number and province) | DATE COLLECTED (DD/MMM/YYYY) | TIME COLLECTED (HH:MM) | ORDERING PHYSICIAN/HEALTHCARE PROVIDER (Provide MSC#) Name and address of report delivery |
| PATIENT SURNAME | PATIENT FIRST AND MIDDLE NAME | | <input type="checkbox"/> I do not require a copy of the report |
| DOB (DD/MMM/YYYY) | GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK | | |
| ADDRESS | | ADDITIONAL COPIES TO: (Address / MSC#) | |
| CITY / TOWN | POSTAL CODE | | 1. |
| SAMPLE REFERENCE NO. | | | 2. |
| | | | 3. |

Section 2 - Clinical Information

| | | | |
|---|-------------------------------|--|--|
| Clinical Information <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Gastrointestinal symptoms <input type="checkbox"/> Headache / Stiff neck <input type="checkbox"/> Respiratory symptoms <input type="checkbox"/> Rash symptoms <input type="checkbox"/> STI contact <input type="checkbox"/> STI symptoms <input type="checkbox"/> Fever <input type="checkbox"/> Other, specify: _____ | | Reason for Test <input type="checkbox"/> Therapeutic monitoring <input type="checkbox"/> NEEDLESTICK <input type="checkbox"/> Immigration <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent <input type="checkbox"/> Prenatal <input type="checkbox"/> Outbreak/Cluster/Event <input type="checkbox"/> Follow-up <input type="checkbox"/> Other, specify: _____ | |
| Recent Travel (Date/Location) | Onset Date DD/MMM/YYYY | History | |

Section 3 - Test(s) Requested (Note: Codes for PHSA Labs Use Only)

| PRENATAL SCREENING (PRENAT) HIV <input type="checkbox"/> HIVCC HIV Non-Nominal Reporting <input type="checkbox"/> HIVCC HBsAg <input type="checkbox"/> HBVP Rubella IgG <input type="checkbox"/> RUBEB Syphilis Antibody <input type="checkbox"/> TPE Other Tests, specify: _____ _____ | HEPATITIS Acute - undefined etiology HBsAg, Anti-HBc Total, Anti-HBs, Anti-HCV, Anti-HAV IgM <input type="checkbox"/> HEP5B Chronic - undefined etiology HBsAg, Anti-HBc Total, Anti-HBs, Anti-HCV <input type="checkbox"/> DHEPCH Hepatitis B Screen HBsAg, Anti-HBs, Anti-HBc Total <input type="checkbox"/> HBSAG Specific Hepatitis Markers Anti-hepatitis A Total (Immune Status) <input type="checkbox"/> HAAT Anti-hepatitis A IgM (Acute Infection) <input type="checkbox"/> HAVMB HBsAg Only <input type="checkbox"/> HBVSA Anti-HBs (Immune Status) <input type="checkbox"/> HBSAB HBeAg (Therapeutic Monitoring) <input type="checkbox"/> HBXEA Anti-HBe (Therapeutic Monitoring) <input type="checkbox"/> HBXEB Anti-HCV <input type="checkbox"/> HEPCB | OTHER SEROLOGY <table border="0"> <tr> <th>Immunity</th> <th>Acute</th> </tr> <tr> <td>Measles IgG (Rubeola) <input type="checkbox"/> MIGB</td> <td>Measles IgM (Rubeola) <input type="checkbox"/> MEASP</td> </tr> <tr> <td>Mumps IgG <input type="checkbox"/> MUIGB</td> <td>Mumps IgM <input type="checkbox"/> MUMPS</td> </tr> <tr> <td>Parvo B19 IgG <input type="checkbox"/> PARVGB</td> <td>Parvo B19 IgM <input type="checkbox"/> PARVP</td> </tr> <tr> <td>Rubella IgG <input type="checkbox"/> RUBEB</td> <td>Rubella IgM <input type="checkbox"/> RUBP</td> </tr> <tr> <td>EBV IgG <input type="checkbox"/> EBGSB</td> <td>EBV IgM <input type="checkbox"/> EBVSP</td> </tr> <tr> <td>CMV IgG <input type="checkbox"/> CMVIGB</td> <td>CMV IgM <input type="checkbox"/> CMVSP</td> </tr> <tr> <td>Varicella IgG <input type="checkbox"/> VZIGB</td> <td>HTLV I / II <input type="checkbox"/> HTLVB</td> </tr> <tr> <td>HSV IgG <input type="checkbox"/> HSVIGB</td> <td><i>H. pylori</i> IgG <input type="checkbox"/> HELIB</td> </tr> </table> | Immunity | Acute | Measles IgG (Rubeola) <input type="checkbox"/> MIGB | Measles IgM (Rubeola) <input type="checkbox"/> MEASP | Mumps IgG <input type="checkbox"/> MUIGB | Mumps IgM <input type="checkbox"/> MUMPS | Parvo B19 IgG <input type="checkbox"/> PARVGB | Parvo B19 IgM <input type="checkbox"/> PARVP | Rubella IgG <input type="checkbox"/> RUBEB | Rubella IgM <input type="checkbox"/> RUBP | EBV IgG <input type="checkbox"/> EBGSB | EBV IgM <input type="checkbox"/> EBVSP | CMV IgG <input type="checkbox"/> CMVIGB | CMV IgM <input type="checkbox"/> CMVSP | Varicella IgG <input type="checkbox"/> VZIGB | HTLV I / II <input type="checkbox"/> HTLVB | HSV IgG <input type="checkbox"/> HSVIGB | <i>H. pylori</i> IgG <input type="checkbox"/> HELIB |
|---|--|--|----------|-------|---|--|--|--|---|--|--|---|--|--|---|--|--|--|---|---|
| Immunity | Acute | | | | | | | | | | | | | | | | | | | |
| Measles IgG (Rubeola) <input type="checkbox"/> MIGB | Measles IgM (Rubeola) <input type="checkbox"/> MEASP | | | | | | | | | | | | | | | | | | | |
| Mumps IgG <input type="checkbox"/> MUIGB | Mumps IgM <input type="checkbox"/> MUMPS | | | | | | | | | | | | | | | | | | | |
| Parvo B19 IgG <input type="checkbox"/> PARVGB | Parvo B19 IgM <input type="checkbox"/> PARVP | | | | | | | | | | | | | | | | | | | |
| Rubella IgG <input type="checkbox"/> RUBEB | Rubella IgM <input type="checkbox"/> RUBP | | | | | | | | | | | | | | | | | | | |
| EBV IgG <input type="checkbox"/> EBGSB | EBV IgM <input type="checkbox"/> EBVSP | | | | | | | | | | | | | | | | | | | |
| CMV IgG <input type="checkbox"/> CMVIGB | CMV IgM <input type="checkbox"/> CMVSP | | | | | | | | | | | | | | | | | | | |
| Varicella IgG <input type="checkbox"/> VZIGB | HTLV I / II <input type="checkbox"/> HTLVB | | | | | | | | | | | | | | | | | | | |
| HSV IgG <input type="checkbox"/> HSVIGB | <i>H. pylori</i> IgG <input type="checkbox"/> HELIB | | | | | | | | | | | | | | | | | | | |
| SYPHILIS (Non Prenatal) Syphilis Antibody <input type="checkbox"/> TPE | | OTHER TESTS (Specify) | | | | | | | | | | | | | | | | | | |
| HIV (Non Prenatal) Note: Patient has the legal right to choose not to have their name reported to public health = non-nominal reporting HIV <input type="checkbox"/> HIVCC Non-Nominal Reporting Requested <input type="checkbox"/> HIVCC | | COMMENTS | | | | | | | | | | | | | | | | | | |
| For other available tests and additional information, consult the Public Health Laboratory's eLab Handbook at www.elabhandbook.info/PHSA/Default.aspx | | | | | | | | | | | | | | | | | | | | |

1 - Patient Information

2 - Clinical Information

Please fill in as completely as possible.

Note: For non-nominal HIV testing omit the patient's PHN

3 - Ordering Physician

4 - Additional Copies To:

The Ordering Physician will receive one copy of the report. Each physician or client listed under Additional Copies To: will receive a copy of the report.

For physicians who work at more than one location, please provide an address for delivery.

5 - Prenatal Testing

Please provide 2 serum separator tubes

Note: Patient has the legal right to choose not to have their name reported to public health (Non-Nominal Reporting).

6 - Syphilis Testing

Please provide 1 serum separator tube.

7- HIV Testing

8 - Hepatitis Testing

9 - Other Serology (except *H. pylori*)

For any combination of testing for HIV, Hepatitis and Other Serology (except *H. pylori*), please provide 1 serum separator tube.

- *H. pylori* Testing

Please provide 1 serum separator tube.

10 - Other Tests

Indicate all additional tests requested. Please consult eLab Handbook for specimen requirements.

| PERSONAL HEALTH NUMBER (per out-of-province Health Number and province) | | DATE COLLECTED (DD/MMM/YYYY) | TIME COLLECTED (PHMM) | ORDERING PHYSICIAN/HEALTHCARE PROVIDER (Provide MSCR Name and address of report delivery) |
|---|--|-------------------------------|-----------------------|---|
| PATIENT SURNAME | | PATIENT FIRST AND MIDDLE NAME | | <div style="text-align: right; font-size: 2em; font-weight: bold;">3</div> <input type="checkbox"/> I do not require a copy of the report |
| DOB (DD/MMM/YYYY) | SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK | | | |
| ADDRESS | | CITY/TOWN | | <div style="text-align: right; font-size: 2em; font-weight: bold;">4</div> ADDITIONAL COPIES TO: (Address / MSCR) |
| POSTAL CODE | | SAMPLE REFERENCE NO. | | 1. 2. 3. |

| Clinical Information | | Reason for Test | |
|--|---|--|--|
| <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Headache / Siff neck <input type="checkbox"/> Rash symptoms <input type="checkbox"/> Fever | <input type="checkbox"/> Gastrointestinal symptoms <input type="checkbox"/> Respiratory symptoms <input type="checkbox"/> STD contact <input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Therapeutic monitoring <input type="checkbox"/> Immigration <input type="checkbox"/> Prenatal <input type="checkbox"/> Follow-up | <input type="checkbox"/> NEEDLESTICK <input type="checkbox"/> Acute <input type="checkbox"/> Outbreak/Cluster/Event <input type="checkbox"/> Convalescent <input type="checkbox"/> Other, specify: _____ |
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For information on sample collection, please call the PHSA Client Services at 1-877-PHSALAB (1-877-747-2522) Form CPSE-100-0001f 1.00 Version 4.0 05/2017 SER