


Section 1 - Patient/Provider Information (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)		ORDERING PRACTITIONER Name and MSC#		LABORATORY USE ONLY
PATIENT SURNAME		Address of report delivery		
PATIENT FIRST AND MIDDLE NAME		<input type="checkbox"/> I do not require a copy of the report <input type="checkbox"/> I am a Locum [†] [†] If Locum, include name of Practitioner you are covering for		
DOB (DD/MMM/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> U (Unk)	ADDITIONAL COPIES TO PRACTITIONER / CLINIC: (Name, Address / MSC# / PHSA Client#) (Limit of 3 copies available)		
PATIENT ADDRESS		1.		DATE RECEIVED
		2.		OUTBREAK ID
CITY		3.		SAMPLE REF. NO.
PROVINCE	POSTAL CODE			DATE COLLECTED (DD/MMM/YYYY)
				TIME COLLECTED (HH:MM)

Section 2 - Test(s) Requested

<p>SAMPLES FOR AFB SMEAR AND MYCOBACTERIUM CULTURE</p> <p>INDICATE SAMPLE TYPE</p> <p><input type="checkbox"/> Sputum</p> <p><input type="checkbox"/> Induced Sputum</p> <p><input type="checkbox"/> Bronchial wash</p> <p><input type="checkbox"/> Tissue, specify source: _____</p> <p><input type="checkbox"/> Body fluid, specify source: _____</p> <p><input type="checkbox"/> Gastric wash (please use only pre-made buffered glass jars from BCCDC)</p> <p><input type="checkbox"/> Urine</p> <p><input type="checkbox"/> Blood</p> <p><input type="checkbox"/> Feces (Clinical history is mandatory)</p> <p><input type="checkbox"/> Other sample, specify: _____</p> <p>Special Test Requests*: _____</p> <p>*Consultation required, please call Medical Microbiologist On-Call at (604) 661-7033</p>	<p>INTER-LABORATORY SAMPLES</p> <p>SAMPLES FOR MYCOBACTERIUM NUCLEIC ACID TESTING</p> <p>Has sample been digested? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has sample been concentrated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Acid-fast smear result: _____</p> <p>Molecular result: _____</p> <p>Specify source: _____</p> <p>CULTURES OF MYCOBACTERIUM</p> <p>Date culture became positive: _____</p> <p>Specify source: _____</p> <p>Special Test Requests*: _____</p> <p>*Consultation required, please call Medical Microbiologist On-Call at (604) 661-7033</p>	
<p>EXPOSURE / TREATMENT HISTORY</p> <p><input type="checkbox"/> Exposure to active TB case</p> <p><input type="checkbox"/> Exposure to MDR or XDR-TB</p> <p>Specify country of exposure: _____</p> <p><input type="checkbox"/> Member of high risk group</p> <p>Specify: _____</p> <p><input type="checkbox"/> Positive TB skin test or interferon-gamma release assay</p> <p><input type="checkbox"/> Currently on TB chemotherapy</p>	<p>CLINICAL HISTORY</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>For other available tests and sample collection information, consult the Public Health Laboratory's <i>eLab Handbook</i> at http://www.elabhandbook.info/PHSA/Default.aspx</p>		<p>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.</p>



Provincial Health Services Authority

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