



BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Zoonotic Diseases & Emerging Pathogens Requisition



Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	DOB (DD/MMM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK
PATIENT SURNAME	PATIENT FIRST AND MIDDLE NAME	
ADDRESS	CITY	POSTAL CODE

DATE RECEIVED
LABORATORY USE ONLY
OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#) Name and address of report delivery	ADDITIONAL COPIES TO: (Address / MSC#) 1. 2. 3.
<input type="checkbox"/> I do not require a copy of the report	
CLINIC OR HOSPITAL Name and address of report delivery	
PHSA CLIENT NO.	

SAMPLE REF. NO.
DATE COLLECTED (DD/MMM/YYYY)
TIME COLLECTED (HH:MM)

Section 3 - Test(s) Requested

VIRUSES	BACTERIA	PARASITES
<input type="checkbox"/> Chikungunya Virus Antibody <input type="checkbox"/> Dengue Virus Antibody <input type="checkbox"/> Hanta Virus Antibody* *for hemorrhagic cases consultation required <input type="checkbox"/> West Nile Virus Antibody <input type="checkbox"/> Zika Virus Antibody and PCR Submit 1 gold top and 1 EDTA blood tube <input type="checkbox"/> Other, specify: _____ Travel / Clinical History Required for Above Tests: (indicate prenatal status for Zika virus): _____ _____ Signs / Symptoms <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Insect bite: <input type="checkbox"/> Skin rash: Type/Location: _____ <input type="checkbox"/> Neurological <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Anti-Streptolysin O (ASO) <input type="checkbox"/> <i>Bartonella henselae</i> <input type="checkbox"/> Antibody <input type="checkbox"/> PCR* <input type="checkbox"/> <i>Borrelia burgdorferi</i> (Lyme disease) <input type="checkbox"/> Antibody <input type="checkbox"/> PCR* <input type="checkbox"/> <i>Borrelia hermsii</i> Antibody <input type="checkbox"/> <i>Bruceella abortus</i> Antibody <input type="checkbox"/> <i>Coxiella burnetii</i> (Q-fever) Antibody <input type="checkbox"/> Diphtheria Antitoxin** <input type="checkbox"/> <i>Francisella tularensis</i> Antibody <input type="checkbox"/> <i>Helicobacter pylori</i> Antigen (Feces) <input type="checkbox"/> <i>Legionella</i> sp. Urine Antigen <input type="checkbox"/> <i>Leptospira</i> spp. <input type="checkbox"/> Antibody <input type="checkbox"/> PCR* <input type="checkbox"/> <i>Rickettsia rickettsii</i> Antibody (Rocky Mountain Spotted Fever) <input type="checkbox"/> Tetanus Antitoxin** <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> <i>Echinococcus</i> spp. Antibody <input type="checkbox"/> <i>Entamoeba histolytica</i> (Amoebiasis) Antibody <input type="checkbox"/> <i>Schistosoma</i> spp. Antibody <input type="checkbox"/> <i>Strongyloides</i> spp. Antibody Travel History Required for Above Tests: <input type="checkbox"/> Travel within past 12 months, specify: _____ _____ <input type="checkbox"/> <i>Leishmania</i> spp. Antibody <input type="checkbox"/> <i>Toxoplasma gondii</i> Antibody <input type="checkbox"/> Immune status IgG <input type="checkbox"/> Acute Infection IgM <input type="checkbox"/> <i>Trichinella</i> spp. Antibody <input type="checkbox"/> <i>Trypanosoma cruzi</i> (American trypanosomiasis) Antibody <input type="checkbox"/> Other, specify: _____
SYPHILIS <input type="checkbox"/> VDRL (CSF sample only) Submit 1 mL CSF in sterile leak-proof tube <input type="checkbox"/> <i>Treponema pallidum</i> Nucleic Acid Testing* Submit exudate, tissue or body fluid <input type="checkbox"/> Darkfield (DF) Microscopy Source of sample: _____ <input type="checkbox"/> Direct Fluorescent Assay (DFA) Microscopy Source of sample: _____ Signs / Symptoms <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Rash <input type="checkbox"/> Other, specify: _____	FUNGI <input type="checkbox"/> <i>Blastomyces dermatidis</i> Antibody <input type="checkbox"/> <i>Coccidioides</i> sp. Antibody <input type="checkbox"/> <i>Cryptococcus neoformans</i> Antigen <input type="checkbox"/> <i>Histoplasma</i> sp. Antibody <input type="checkbox"/> Other, specify: _____ Travel History Required for Above Tests: <input type="checkbox"/> Travel within past 12 months, specify: _____	<p style="text-align: center;">* CONSULTATION REQUIRED Please telephone Program Head (Clinical Microbiologist) at (604) 707-2622</p> <p style="text-align: center;">** MUST BE <17 YEARS OLD OR ORGAN TRANSPLANT PATIENT</p> <p style="text-align: center;">For other available tests and additional information, consult the Public Health Laboratory's <i>eLab Handbook</i> at www.elabhandbook.info/PHSA/Default.aspx</p>



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