



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				
CITY				
PROVINCE	POSTAL CODE	1.		
		2.		
		3.		
		OUTBREAK ID		
		SAMPLE REF. NO.		
		DATE COLLECTED (DD/MMM/YYYY)		
		TIME COLLECTED (HH:MM)		

Section 2 - Test(s) Requested

<p>RESPIRATORY PATHOGENS</p> <input type="checkbox"/> Influenza A, Influenza B, RSV <input type="checkbox"/> COVID-19 <input type="checkbox"/> MERS (Approval and travel history required*) <input type="checkbox"/> Enterovirus D68 (Seasonal; when outside season, approval required) <input type="checkbox"/> Other, specify: _____ Indicate sample site: <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Nares <input type="checkbox"/> Oropharynx <input type="checkbox"/> Throat <input type="checkbox"/> Lower Respiratory Tract: _____ <input type="checkbox"/> Other, specify: _____ Indicate container type: <input type="checkbox"/> Swab with transport media <input type="checkbox"/> Saline gargle <input type="checkbox"/> Wash: _____ <input type="checkbox"/> Others: _____		For other available tests and sample collection information, consult the Public Health Laboratory's <i>eLab Handbook</i> : www.elabhandbook.info/PHSA/Default.aspx	
		<p>PATIENT STATUS / TRAVEL HISTORY* / EXPOSURE (Please provide travel history where indicated*)</p> <p>_____</p> <p>_____</p>	<p>OUTBREAK LOCATION / INFORMATION</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>VIRUS SUBTYPING</p> <input type="checkbox"/> Influenza A <input type="checkbox"/> Adenovirus (Surveillance/outbreak investigations only) Ct value: _____ or viral signal: weak / strong HEPATITIS VIRUSES Please see the Serology Screening Requisition to order HCV RNA and/or HCV genotyping testing.		<p>HERPES SIMPLEX 1,2 / VARICELLA ZOSTER VIRUSES</p> <input type="checkbox"/> Genital lesion swab <input type="checkbox"/> Non-genital lesion swab <input type="checkbox"/> Skin swab <input type="checkbox"/> Other, specify: _____ ENCEPHALITIS VIRUSES Cerebrospinal Fluid for: <input type="checkbox"/> HSV 1, HSV 2, VZV and Enterovirus <input type="checkbox"/> West Nile virus (Seasonal) (Summer/early fall; when outside of season, specify travel history to endemic area*) <input type="checkbox"/> Other, specify: _____ (Note: Send CSF from <6 months old directly to BC Children's & Women's Hospital Laboratory for testing that includes parechovirus)	
		<p>MEASLES</p> <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Urine <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Recent MMR vaccination <input type="checkbox"/> Recent travel (Provide travel history if available*)	<p>MUMPS</p> <input type="checkbox"/> Buccal/Oral swab <input type="checkbox"/> Urine <input type="checkbox"/> Other, specify: _____
		<p>GASTROINTESTINAL VIRUSES Feces** for: <input type="checkbox"/> Gastrointestinal Panel (Norovirus, Adenovirus, Astrovirus, Rotavirus, Sapovirus) <input type="checkbox"/> Enterovirus <input type="checkbox"/> Other, specify: _____ **Guideline for Ordering Stool Specimens www.bcguidelines.ca/gpac/guideline_diarrhea.html </p>	
		<p>BIOPSY / AUTOPSY / OTHER TESTS</p> <input type="checkbox"/> Plasma for West Nile virus (Seasonal) <input type="checkbox"/> Eye sample for Adenovirus, HSV 1, HSV 2, VZV <input type="checkbox"/> Other, specify: _____	
		<p>RUBELLA</p> <input type="checkbox"/> Nasopharyngeal washing/swab <input type="checkbox"/> Throat swab <input type="checkbox"/> Urine <input type="checkbox"/> Other, specify: _____	

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.



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

