



PHN / Healthcare Number		Pt. Hosp. #		Lab Accession #				<input type="checkbox"/> Copy to Name _____		
<input type="checkbox"/> M <input type="checkbox"/> F	Patient Legal Name (last, first, initial)			DOB	DD	MM	YY	Physician Code _____		
Address		City		Prov.	Postal Code			Bill Type CPL <input type="checkbox"/> Alberta Health Care OR CO <input type="checkbox"/> Company OT <input type="checkbox"/> Out of Prov XX <input type="checkbox"/> Pre-paid PB <input type="checkbox"/> Patient Bill		
Chart #		Patient Phone #		Lab #				Co. Name _____		
Ordering Physician / Practitioner			Physician Code		Specimen Event Type				Address _____	
Ordering Address / Location			Report Location Code		IA <input type="checkbox"/> Auxillary IP <input type="checkbox"/> Inpatient OP <input type="checkbox"/> Outpatient AP <input type="checkbox"/> Ambulatory HC <input type="checkbox"/> Home Care ST <input type="checkbox"/> Staff EN <input type="checkbox"/> Environ WCB <input type="checkbox"/> Workers Comp				Client # _____	
Report address if different									Comments	
Date specimen collected		Test Status		Specimen Type		Body Fluid				
DD	MM	YY	<input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> STAT				<input type="checkbox"/> Blood <input type="checkbox"/> CSF Other _____			
Time (24 h)										

Viral	Bacterial	Fungal
<p>Hepatitis (complete box A and D on reverse)</p> <input type="checkbox"/> HAV IgM <input type="checkbox"/> HAV IgG (Immunity) <input type="checkbox"/> HBV DNA* <input type="checkbox"/> HBsAg <input type="checkbox"/> HBs Ab (Immunity) <input type="checkbox"/> HBc IgG <input type="checkbox"/> HBc IgM <input type="checkbox"/> HBeAg <input type="checkbox"/> HBe Ab <input type="checkbox"/> HCV Ab <input type="checkbox"/> HCV RNA RT-PCR* <input type="checkbox"/> Other (specify) _____ _____ _____ <p>*Consult Lab before submitting request.</p> <p>HIV (complete box F on reverse)</p> <input type="checkbox"/> HIV Ab <input type="checkbox"/> Other (specify) _____ _____ _____	<p>Miscellaneous (complete box A on reverse)</p> <input type="checkbox"/> CMV Ab IgG <input type="checkbox"/> CMV Ab IgM <input type="checkbox"/> EBV Monospot <input type="checkbox"/> EBV VCA IgM <input type="checkbox"/> EBNA IgG <input type="checkbox"/> HSV IgG <input type="checkbox"/> Measles IgG <input type="checkbox"/> Measles IgM <input type="checkbox"/> Mumps IgG <input type="checkbox"/> Mumps IgM <input type="checkbox"/> Parvovirus B19 IgG <input type="checkbox"/> Parvovirus B19 IgM <input type="checkbox"/> Rabies <input type="checkbox"/> Rubella IgG (complete box B on reverse) <input type="checkbox"/> Rubella IgM (complete box B on reverse) <input type="checkbox"/> Varicella Zoster IgG <input type="checkbox"/> Varicella Zoster IgM <p>Streptococcal <input type="checkbox"/> Anti-DNase B</p> <p>Syphilis (complete box C on reverse)</p> <input type="checkbox"/> DFA-Tp <input type="checkbox"/> RPR <input type="checkbox"/> Syphilis Serology <input type="checkbox"/> VDRL <p>Other (complete box A on reverse)</p> <input type="checkbox"/> Brucella <input type="checkbox"/> Chlamydomphila pneumoniae <input type="checkbox"/> Chlamydomphila psittaci <input type="checkbox"/> Diphtheria <input type="checkbox"/> Francisella <input type="checkbox"/> Legionella <input type="checkbox"/> Leptospira <input type="checkbox"/> Lyme disease <input type="checkbox"/> Mycoplasma pneumoniae <input type="checkbox"/> Rickettsia <input type="checkbox"/> Tetanus <input type="checkbox"/> Yersinia <input type="checkbox"/> Other (specify) _____ _____ _____	<p>(complete box A on reverse)</p> <input type="checkbox"/> Aspergillus sp. <input type="checkbox"/> Blastomyces sp. <input type="checkbox"/> Coccidioides sp. <input type="checkbox"/> Histoplasma sp. <input type="checkbox"/> Other (specify) _____ _____ _____ <p>Parasite Serology (complete box A on reverse)</p> <input type="checkbox"/> Cysticercosis <input type="checkbox"/> Echinococcus <input type="checkbox"/> Strongyloides <input type="checkbox"/> Toxoplasma IgG <input type="checkbox"/> Toxoplasma IgM <input type="checkbox"/> Other (specify) _____ _____ _____

Box A – Patient History Asymptomatic

Patient Status

Normal Immunocompromised patient Antimicrobial / Antiviral in use

Neonate Malignant disease _____

Pregnant Organ transplant _____

Injection drug user (IDU) _____ Recent travel (country) _____

Organ donor _____

Other (specify) _____

Please complete the following sections as the information provided determines which tests are performed

Date of onset

D	D	M	M	M	Y	Y
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 Previous blood sent? Yes No

Signs and Symptoms (check and add where appropriate)

General fever weight loss
 fatigue night sweats

Rash macular petechial / purpuric papular
 erythema multiforme vesicular ulcers
Other (specify) _____

Neurological and Musculoskeletal headache seizures myositis
 confusion arthralgia encephalitis
 arthritis meningitis myalgia
Other (specify) _____

Gastrointestinal nausea / vomiting acute hepatitis diarrhea
 chronic liver disease jaundice
Other (specify) _____

Genito-urinary hemorrhagic cystitis
Other (specify) _____

Hematologic hemolytic anemia marrow aplasia
 lymphadenopathy thrombocytopenia
 splenomegaly
Other (specify) _____

Miscellaneous conjunctivitis effusion (site)
 myocarditis pericarditis
 abortion intrauterine growth retardation
Other (specify) _____

Box B – Rubella Serology

Immune status Yes No

Rash or other acute symptom(s) Yes No

Previous immunization Yes No
 Unknown

Box C - Syphilis Serology

Prenatal Suspect

Visa Follow up

Previous Lab #: _____

Box D – Hepatitis
(Also complete Box A)

Previous hepatitis results

	POS	NEG
HAV IgG	<input type="checkbox"/>	<input type="checkbox"/>
HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>
HBV		
specify _____	<input type="checkbox"/>	<input type="checkbox"/>
HBsAg	<input type="checkbox"/>	<input type="checkbox"/>
HCV Ab	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
Needlestick	<input type="checkbox"/>	<input type="checkbox"/>
Other exposure	<input type="checkbox"/>	<input type="checkbox"/>
Post-transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Hep. immunization	<input type="checkbox"/>	<input type="checkbox"/>

Box E - Specify Request(s)/Comments

Box F - Please indicate all conditions which apply

Clinical

Previous HIV test

Positive
 Negative
 Never done
 Unknown

Date / Lab # of last HIV test _____

Symptoms suggestive of AIDS/HIV Opportunistic infections
 Kaposi's sarcoma Other malignancies
 Other _____

Non-Medical/Non-Public Health
(Third Party – separate fee applies)

Visa
 Insurance
 Foreign pre-employment requirement
 Participate in research study

Risk Information/Reason for Testing

Anxiety Occupational exposure

Bi-sexual Offspring of patient with AIDS or positive HIV serology

Exposure to blood/body fluids Organ donor

Hemophiliac Recipient of blood/blood products

Homosexual Sexual assault

Injection drug user (IDU) Sexual contact in / with person from global endemic area

Multiple sexual partners (including prostitutes) Sexual partner of patient with AIDS or positive HIV serology

Homosexual Homosexual

Heterosexual Heterosexual

Needlestick TB case

Source Recipient

Other reason _____