

PHN / Healthcare Number		Pt. Hosp. #	Lab Accession #		<input type="checkbox"/> Copy to Name _____ Physician Code _____ Address _____							
<input type="checkbox"/> M	Patient Legal Name (Last, First, Middle Initial)			Date of Birth (dd-mm-yy)								
<input type="checkbox"/> F	Address		City	Prov	Postal Code							
Chart #		Patient Phone #		Lab #								
Ordering Physician/Practitioner			Physician Code		<b>Specimen Event Type</b> 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"/> Worker's Comp							
Ordering Address/Location			Report Location Code									
Report address if different			<b>Bill Type</b> <input type="checkbox"/> 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  Co. name _____ Address _____ Client # _____									
Date specimen collected (dd-mm-yy)												
Time (24 h)		<b>Specimen Type</b> <table style="width:100%; border:none;"> <tr> <td style="width:25%; vertical-align: top;"> <b>Body Fluid</b>  <input type="checkbox"/> Blood  <input type="checkbox"/> CSF  <input type="checkbox"/> Bone marrow  <input type="checkbox"/> Urine  <input type="checkbox"/> Gastric washings  <input type="checkbox"/> Other (*specify) _____         </td> <td style="width:25%; vertical-align: top;"> <b>Respiratory</b>  <input type="checkbox"/> Auger suction  <input type="checkbox"/> Bronchial alveolar lavage  <input type="checkbox"/> Bronchial washing  <input type="checkbox"/> Bronchial brush  <input type="checkbox"/> ETT         </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Nasopharynx  <input type="checkbox"/> Nose  <input type="checkbox"/> Sputum  <input type="checkbox"/> Other (*specify) _____         </td> <td style="width:25%; vertical-align: top;"> <b>Wound/Skin/Surgical</b>          (Specify site)  <input type="checkbox"/> Abscess  <input type="checkbox"/> Aspirate  <input type="checkbox"/> Biopsy  <input type="checkbox"/> Bone chip  <input type="checkbox"/> IV tip         </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Skin scraping  <input type="checkbox"/> Tissue  <input type="checkbox"/> Wound Swab  <input type="checkbox"/> Other (specify) _____         </td> <td style="width:25%; vertical-align: top;"> <b>Genital</b>  <input type="checkbox"/> Cervix  <input type="checkbox"/> Urethra  <input type="checkbox"/> Vagina  <input type="checkbox"/> Other (specify) _____         </td> <td style="width:25%; vertical-align: top;"> <b>Gastrointestinal</b>  <input type="checkbox"/> Feces  <input type="checkbox"/> Emesis  <input type="checkbox"/> Other (specify) _____         </td> </tr> </table>				<b>Body Fluid</b> <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Bone marrow <input type="checkbox"/> Urine <input type="checkbox"/> Gastric washings <input type="checkbox"/> Other (*specify) _____	<b>Respiratory</b> <input type="checkbox"/> Auger suction <input type="checkbox"/> Bronchial alveolar lavage <input type="checkbox"/> Bronchial washing <input type="checkbox"/> Bronchial brush <input type="checkbox"/> ETT	<input type="checkbox"/> Nasopharynx <input type="checkbox"/> Nose <input type="checkbox"/> Sputum <input type="checkbox"/> Other (*specify) _____	<b>Wound/Skin/Surgical</b> (Specify site) <input type="checkbox"/> Abscess <input type="checkbox"/> Aspirate <input type="checkbox"/> Biopsy <input type="checkbox"/> Bone chip <input type="checkbox"/> IV tip	<input type="checkbox"/> Skin scraping <input type="checkbox"/> Tissue <input type="checkbox"/> Wound Swab <input type="checkbox"/> Other (specify) _____	<b>Genital</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Vagina <input type="checkbox"/> Other (specify) _____	<b>Gastrointestinal</b> <input type="checkbox"/> Feces <input type="checkbox"/> Emesis <input type="checkbox"/> Other (specify) _____
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Test Status		<input type="checkbox"/> Routine <input type="checkbox"/> Priority <input type="checkbox"/> STAT										

<b>Bacteriology</b> <input type="checkbox"/> Bordetella pertussis <input type="checkbox"/> Chlamydia trachomatis <input type="checkbox"/> Clostridium difficile <input type="checkbox"/> Culture / Sensitivity <input type="checkbox"/> G C Screen <input type="checkbox"/> Legionella Culture <input type="checkbox"/> Mycobacterium (TB) culture <input type="checkbox"/> AFB smear only  <input type="checkbox"/> Mycoplasma culture <input type="checkbox"/> Other (specify) _____	<b>Molecular Diagnostics*</b> <input type="checkbox"/> specify _____ *Consult laboratory  <b>Mycology</b> <input type="checkbox"/> Fungus culture / exam <input type="checkbox"/> Other (specify) _____	<b>Parasitology</b> <input type="checkbox"/> Ova and Parasites <input type="checkbox"/> Direct examination <input type="checkbox"/> Other (specify) _____  <b>Virology</b> Culture and Identification (complete box A and E on reverse) <input type="checkbox"/> Culture <input type="checkbox"/> DFA <input type="checkbox"/> Electron microscopy <input type="checkbox"/> Other (specify) _____
<b>Serology</b> <b>Viral</b> <b>Hepatitis</b> (complete box A and D on reverse) <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 Ab <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) _____ *Consult Lab before submitting request  <b>HIV</b> (complete box F on reverse) <input type="checkbox"/> HIV Ab <input type="checkbox"/> Other (specify) _____	<b>Bacterial</b> <b>Streptococcal</b> <input type="checkbox"/> Anti-DNase B  <b>Syphilis</b> (complete box C on reverse) <input type="checkbox"/> DFA-Tp <input type="checkbox"/> RPR <input type="checkbox"/> Syphilis Serology <input type="checkbox"/> VDRL  <b>Other</b> (complete box A on reverse) <input type="checkbox"/> Brucella <input type="checkbox"/> Chlamydia pneumoniae <input type="checkbox"/> Chlamydia 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) _____	<b>Fungal</b> (complete box A on reverse) <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) _____  <b>Parasite Serology</b> (complete box A on reverse) <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) \_\_\_\_\_

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
---	---	---	---	---	---	---

 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 \_\_\_\_\_