ALBERTA PRECISION LABORATORIES

Leaders in Laboratory Medicine

MOBILE COLLECTION SERVICE REQUISITION

ORDERING PHYSICIAN (Include Full Name, Client # and Provider #)

PROVINCE	PERSONAL HEALTH NUMBER (PHN)	REGIONAL HEALTH RECORD NUMBER
	____ ____ ____ ____ ____ – ____ ____ ____ ____	

PATIENT LAST NAME | FULL FIRST NAME | MIDDLE NAME

PATIENT ADDRESS | CITY, PROVINCE | POSTAL CODE

CHART NUMBER	GENDER	DATE OF BIRTH	PATIENT PHONE NUMBER
		____ ____ ____ / ____ ____ / ____ ____ (Y Y Y Y / M M M / D D)	(___) ___ - ____

CLINICAL DATA

ACCESSION NUMBER
(For mobile lab use only)

COPY TO:

1) _____ Last Name _____ Full First Name _____ Office Address/Location

2) _____ Last Name _____ Full First Name _____ Office Address/Location

Patient Eligibility Requirements

Select one of the following eligibility criteria for the patient to receive mobile services:

- ❑ The patient has had a recent hospitalization and/or surgery that temporarily restrict their travel outside the home (maximum 4 weeks).
  Specify reason: _____
  Hospital discharge date: (yyyy-mmm-dd) _____
- ❑ The patient has an ongoing medical restriction and is unable to attend appointments or other activities outside the home.
  Specify Condition impeding mobility: _____
- ❑ The patient resides in a secured or safe living environment e.g. Remand Centre, Dementia Unit.

Scheduling Requirements

Requested Start Week of: _____ (Service date will be determined by patient location/address)

Select testing frequency and mobile order history:

Frequency	Maximum Duration
❑ Once only	Once
❑ 2X /Week	2 weeks (M/Th or Tu/F)
❑ 3X /Week	2 weeks (M/W/F)
❑ Weekly	3 months
❑ Every 2 Weeks	6 months
❑ Monthly	1 year
❑ Every 3 Months	1 year
For other frequencies consult mobile services.	

If this patient has an existing Mobile order check one of the following:

- ❑ Addition to next scheduled collection
- ❑ Replacement of all existing orders
- ❑ Schedule extra collection week of: _____
  Specify reason if specific date required: _____

Test Selection

ALB	❑	Albumin
ALP	❑	Alkaline Phosphatase
ALT	❑	Alanine Aminotransferase
BILT	❑	Bilirubin – Total Only
CA	❑	Calcium
CBC	❑	CBC includes differential
CK	❑	Creatine Kinase
CREA	❑	Creatinine
EP	❑	Electrolytes (Na, K, Cl)
FERR	❑	Ferritin
GGT	❑	Gamma Glutamyl Transferase
GLU	❑	Glucose
HBA1C	❑	Hemoglobin A1c (Max once every 3 months)
LDL	❑	Lipid Profile
MG	❑	Magnesium
PT	❑	INR (Prothrombin Time)
TNT	❑	Troponin
TSH	❑	TSH
UREA	❑	Urea
U	❑	Urine (includes microscopic as per protocol)
UMALB	❑	Urine Albumin
ECG	❑	Electrocardiogram

OTHER TESTS NOT LISTED:

THERAPEUTIC DRUG MONITORING

Last Dose Time: ____:____ Date: _____ ❑ Pre ❑ Post ❑ Random

Route: ❑Oral ❑ IM ❑ IV

CARB	❑	Carbamazepine
CYCLO	❑	Cyclosporin
DIG	❑	Digoxin (Must be collected 8 hrs after last dose)
GEN	❑	Gentamicin
LI	❑	Lithium
PTN	❑	Phenytoin - Total
SIRO	❑	Sirolimus
TACRO	❑	Tacrolimus
VALP	❑	Valproate
VANC	❑	Vancomycin

FAX COMPLETED FORM TO APL MOBILE OFFICE @ 403-777-5222