

Date: September 28, 2016
To: SZW Physicians, Nursing, Primary Care Networks, Pharmacists, Laboratory Staff
From: AHS Laboratory Services
Re: New South Zone Laboratory and Microbiology Requisitions

PLEASE POST OR DISTRIBUTE AS WIDELY AS APPROPRIATE

New South Zone Laboratory and Microbiology Requisitions

Key Messages:

- Effective October 17, 2016, new South Zone Laboratory and Microbiology Requisitions will be available for use across South Zone.
- The former South Zone Laboratory/Microbiology Requisition (form 101940) has been divided into two separate forms: South Zone Laboratory Requisition (form 20572) and South Zone Microbiology Requisition (form 20571). The Microbiology requisition is no longer on the reverse of the Laboratory requisition.

Why this is important:

- Laboratory and Microbiology requisitions are being updated and standardized across South Zone.
- These new requisitions replace all former laboratory and microbiology requisitions from AHS South Zone West, South Zone East, and Medicine Hat Diagnostic Laboratory.
- Requisitions will be distributed in pads of 100.

Action Required:

- All microbiology testing should be sent to the lab using the new South Zone Microbiology Requisition (form 20571) beginning October 17, 2016.
- The current SZW Laboratory/Microbiology requisition may continue to be used for laboratory test requests only. This form will be replaced with the new Laboratory requisition (form 20572) when the current stock is depleted.
- Ensure patient demographic information, requestor and “copy to” information is completed in full. Illegible or missing information results in the inability of the laboratory to deliver results to the appropriate caregiver in a timely manner.

How to Order

- Community Physicians: Laboratory and Microbiology requisitions may be ordered using the Physician Office Printing Order Sheet.
- Meditech users: The Laboratory Requisition will automatically replace the former SZW Laboratory/Microbiology requisition and has the same stores order number. The Microbiology requisition will be added to the Meditech ordering system.

	Form #	Meditech #
South Zone Laboratory Requisition	20572	0525890 (same as previous)
South Zone Microbiology Requisition	20571	0015214

- To obtain electronic copies for loading into POSP systems, contact AHS Forms Management at formsmanagement@ahs.ca
- Low-volume users who do not wish to order pads of 100 may print individual copies of the requisition from the Alberta Health Services website:
 - Laboratory Requisition: <http://www.albertahealthservices.ca/frm-20572.pdf>
 - Microbiology Requisition: <http://www.albertahealthservices.ca/frm-20571.pdf>

Important Changes:

- The laboratory and microbiology requisitions have been separated.
- New requisitions use the standard Alberta Health Services demographic fragment.
- Updates to test listing with priority given to testing performed in South Zone and the most frequently referred out tests.
- Tests that require forms/requisitions from referral laboratories have been removed (eg. Malaria, Prenatal screening).
- Microbiology:
 - Ova and Parasites: Previously there was one test code for Ova and Parasite testing (**OPI**). There are now two tests and codes:
 - Cryptosporidium/Giardia screening (**CRYSGIA**) which may be ordered without significant clinical or travel history.
 - Ova and Parasite Investigation (**OPI**), which requires significant clinical or travel history. These histories include: Travel to/residence in a developing country, Bloody stool, Immunocompromised and Eosinophilia. This test includes a Cryptosporidium/Giardia screen.
 - Vaginal Cultures: Tests that were previously bundled as part of the “genital culture” (**CUGEN**) request must now be explicitly and separately ordered on a requisition or in Meditech OE. These tests include:
 - Bacterial vaginosis/yeast (**VAGS**)
 - Trichomonas testing (**TRICHVAG**)
 - Vaginal culture (**CUGEN**) requires significant patient history. These histories include Toxic shock, Endometritis, GU surgery and sexual assault.

Links

- South Zone West Test Directory: <http://www.albertahealthservices.ca/lab/page7695.aspx>
- AHS Sample Acceptance Policy: <http://www.albertahealthservices.ca/assets/wf/lab/wf-lab-sample-acceptance-appendix-a-dec-2012nm.pdf>

Inquiries and feedback may be directed to:

- Ron Schulz, Quality Coordinator, South Zone. Ron.Schulz@ahs.ca
- Barb Collin, Supervisor, CRH Accession. Barbara.Collin@ahs.ca

This bulletin has been reviewed and approved by:

Dr. Michael Greeff, South Zone Laboratory Clinical Co-Lead
Dorothy Ward, South Zone Laboratory Director

Patient	PHN	Alternate Identifier		Date of Birth (yyyy-Mon-dd)	
	Last Name	First Name	Middle	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Phone
	Address	City/Town	Prov	Postal Code	Location
Requestor (s)	Requestor Name (last, first)		Copy to (last, first)		Copy to (last, first)
	Location/Facility/Address		Location/Facility/Address		Location/Facility/Address
	Phone		Phone		Phone
	Healthcare Provider ID		Healthcare Provider ID		Healthcare Provider ID
Collection	Date (yyyy-Mon-dd)	Time (24 hr)	Location	Collector ID	

Required Clinical Information	
Suspected Organism/Diagnosis/Clinical History Eye, Ear, Nose, Throat Culture <input type="checkbox"/> Throat, Group A Strep (CUTHR) <input type="checkbox"/> Penicillin Allergy? <input type="checkbox"/> Mouth, Yeast (CUO) <input type="checkbox"/> Nose, Staph aureus (CUN) <input type="checkbox"/> Ear (CUEAR) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Eye (CUEYE) <input type="checkbox"/> Left <input type="checkbox"/> Right Respiratory <input type="checkbox"/> Resp. Syncytial Virus (RSV) <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Auger suction <input type="checkbox"/> Sputum Culture (CUSPU) <input type="checkbox"/> Expecterated <input type="checkbox"/> Suction <input type="checkbox"/> Cystic Fibrosis? <input type="checkbox"/> Respiratory Culture (CURES) <input type="checkbox"/> Auger Suction <input type="checkbox"/> Bronchial Washings <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bronchoalveolar Lavage <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> TB/AFB Culture (TBCU) <input type="checkbox"/> Brushing <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Fungal Culture (FUNINV) Other _____ Gastrointestinal Culture <input type="checkbox"/> Stool Culture (CUST) <input type="checkbox"/> Bloody Specimen? <input type="checkbox"/> C diff toxin (CDTOX) Ova & Parasites <input type="checkbox"/> Cryptosporidium/Giardia Screen Only (CRYSGIA) <input type="checkbox"/> Ova & Parasite Investigation: Significant history required (OPI) <input type="checkbox"/> Travel to/residence in _____ Location developing country <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Eosinophilia <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Other _____ <input type="checkbox"/> Pinworm (PIN) <input type="checkbox"/> Worm Identification (WORMID) Blood and Sterile Body Fluids <input type="checkbox"/> Blood Culture (CUB) <input type="checkbox"/> Blood Culture – Fungus (CUBFUN) <input type="checkbox"/> CSF Culture (CUCSF) Phone Lab if CJD Risk <input type="checkbox"/> Body Fluid Culture (CUBF) <input type="checkbox"/> Synovial <input type="checkbox"/> Peritoneal <input type="checkbox"/> Dialysate <input type="checkbox"/> Pleural <input type="checkbox"/> Bursa <input type="checkbox"/> Other _____ Infection Control Screen <input type="checkbox"/> MRSA Screen (MRSA) <input type="checkbox"/> Nasal <input type="checkbox"/> Urine <input type="checkbox"/> Rectal/stool <input type="checkbox"/> Groin <input type="checkbox"/> VRE Screen (VRE) <input type="checkbox"/> Rectal/stool	Current or Recent Antibiotics/Antifungals Urine <input type="checkbox"/> Urine Culture (CUU) <input type="checkbox"/> Midstream <input type="checkbox"/> Urine bag <input type="checkbox"/> Symptomatic? <input type="checkbox"/> Catheter (Specify) _____ <input type="checkbox"/> Pregnant? <input type="checkbox"/> Other _____ If Neither, Indication Required: <input type="checkbox"/> GU Surgery <input type="checkbox"/> Other _____ Genital Tract <input type="checkbox"/> Bacterial vaginosis/yeast (VAGS) <input type="checkbox"/> Trichomonas (TRICHVAG) <input type="checkbox"/> Group B Strep (GBS) Pregnant Only <input type="checkbox"/> Penicillin Allergy? <input type="checkbox"/> Chlamydia/Gonorrhea (CHLGC PROV1) <input type="checkbox"/> Vaginal (pink APTIMA vag swab) <input type="checkbox"/> Urine (Initial 30mL only) <input type="checkbox"/> Cervix <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal (blue APTIMA unisex swab) <input type="checkbox"/> Genital Culture (CUGEN) <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra (charcoal swab) Significant History Required <input type="checkbox"/> Toxic Shock <input type="checkbox"/> GU Surgery <input type="checkbox"/> Vagina <input type="checkbox"/> Endometritis <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Other _____ Wounds, Tissue, Drainage Specimen/Site Description (MUST specify) <input type="checkbox"/> Superficial Culture <2cm (CUSUP) <input type="checkbox"/> Wound Swab (Aerobic only) <input type="checkbox"/> Abscess <input type="checkbox"/> Drainage <input type="checkbox"/> Deep Culture >2cm <input type="checkbox"/> Wound Swab <input type="checkbox"/> Bite <input type="checkbox"/> Aerobic culture only (CUSUP) <input type="checkbox"/> Deep Abscess <input type="checkbox"/> Aspirate <input type="checkbox"/> Aerobic and anaerobic culture (CUWD) <input type="checkbox"/> Other _____ <input type="checkbox"/> Foreign Body Culture (CUFB) <input type="checkbox"/> Catheter Tip <input type="checkbox"/> IUD <input type="checkbox"/> Other _____ <input type="checkbox"/> Tissue Culture (CUTI) <input type="checkbox"/> Bone Culture (CUBO) <input type="checkbox"/> Dermatophytes - Fungus (FUNINV) <input type="checkbox"/> Hair <input type="checkbox"/> Skin <input type="checkbox"/> Nails Other Tests / Comments

Appointments:
 Lethbridge 403.388.6201

Client Service Centre:
 Lethbridge 403.388.6057

Patient	PHN	Alternate Identifier		Date of Birth (yyyy-Mon-dd)	
	Last Name	First Name	Middle	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Phone
	Address	City/Town	Prov	Postal Code	Location
Requestor (s)	Requestor Name (last, first)		Copy to (last, first)		Copy to (last, first)
	Location/Facility/Address		Location/Facility/Address		Location/Facility/Address
	Phone		Phone		Phone
	Healthcare Provider ID		Healthcare Provider ID		Healthcare Provider ID

Collection	Date (yyyy-Mon-dd)	Time (24 hr)	Location	Collector ID
-------------------	--------------------	--------------	----------	--------------

Priority: Routine Stat Urgent Timed **(F) Denotes a Fasting Test**

Hematology <input type="checkbox"/> CBC & Diff <input type="checkbox"/> Retic Count Coagulation <input type="checkbox"/> INR <input type="checkbox"/> PTT <input type="checkbox"/> D-Dimer <input type="checkbox"/> Fibrinogen Transfusion Medicine <input type="checkbox"/> ABORH <input type="checkbox"/> ABORH&AB Screen (ABSG) <input type="checkbox"/> Direct Antiglobulin Test (DAT) <input type="checkbox"/> Type and Screen (TS) Transfusion: <input type="checkbox"/> RBC <input type="checkbox"/> Other _____ # of Units _____ Date/Time _____ Location _____ Antibodies _____ Prev Transfusion/Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	Chemistry <input type="checkbox"/> Electrolyte Panel (LYTE) <input type="checkbox"/> Sodium (NA) <input type="checkbox"/> Potassium (K) <input type="checkbox"/> Osmolality, Serum <input type="checkbox"/> Creatinine <input type="checkbox"/> Urea <input type="checkbox"/> Glucose <input type="checkbox"/> Fasting (F) <input type="checkbox"/> Random <input type="checkbox"/> Hemoglobin A1C (HBA1C) <input type="checkbox"/> 2 hr glucose tolerance (F) (GLUT2) <input type="checkbox"/> Patient Meter - Lab Correlation <input type="checkbox"/> Fasting (F) <input type="checkbox"/> Random (GLUMLF/R) <input type="checkbox"/> Bilirubin <input type="checkbox"/> Total <input type="checkbox"/> Direct <input type="checkbox"/> Bilirubin, Neonate <input type="checkbox"/> Carcinoembryonic Ag (CEA) <input type="checkbox"/> Ferritin <input type="checkbox"/> Iron, IBC, Index <input type="checkbox"/> Vitamin B12 (B12) <input type="checkbox"/> Calcium <input type="checkbox"/> Magnesium (MG) <input type="checkbox"/> Phosphate <input type="checkbox"/> Urate (Uric Acid) <input type="checkbox"/> Lipid Profile <input type="checkbox"/> Cholesterol <input type="checkbox"/> Triglycerides (F) <input type="checkbox"/> CVD Risk Assessment Systolic BP _____ History (check all that apply): <input type="checkbox"/> Tobacco <input type="checkbox"/> Treated for high BP <input type="checkbox"/> Diabetes <input type="checkbox"/> CKD <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> 1° relative <60y with CVD	Endocrine / Thyroid <input type="checkbox"/> Cortisol <input type="checkbox"/> 0800 <input type="checkbox"/> 1600 <input type="checkbox"/> Estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> TSH <input type="checkbox"/> Progressive <input type="checkbox"/> Progesterone <input type="checkbox"/> Prolactin <input type="checkbox"/> PSA <input type="checkbox"/> Testosterone Immunology/Serology <input type="checkbox"/> Anti-Nuclear Ab (ANA) <input type="checkbox"/> Anti-streptolysin O (SO) <input type="checkbox"/> Anti-transglutaminase (TRANSAB) <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Hep A IgM (Infection) (HAVIGM) <input type="checkbox"/> Hep A IgG (Immunity) (HAVIGG) <input type="checkbox"/> Hep B Surface Ag (HBSAGRO) <input type="checkbox"/> Hep B Ab (Immunity) (HBSABRO) <input type="checkbox"/> Hep C Antibody (HCVAB) <input type="checkbox"/> Rheumatoid Factor (RF) <input type="checkbox"/> Rubella IgG (Immunity) <input type="checkbox"/> Syphilis serology	Urine <input type="checkbox"/> Urinalysis (UA) <input type="checkbox"/> Albumin <input type="checkbox"/> Random <input type="checkbox"/> Timed <input type="checkbox"/> Calcium <input type="checkbox"/> Random <input type="checkbox"/> 24 Hr <input type="checkbox"/> Osmolality <input type="checkbox"/> Protein <input type="checkbox"/> Random <input type="checkbox"/> 24 Hr <input type="checkbox"/> Phosphorus <input type="checkbox"/> Random <input type="checkbox"/> 24 Hr <input type="checkbox"/> Urate (Uric Acid), 24 hr <input type="checkbox"/> Creatinine <input type="checkbox"/> Random <input type="checkbox"/> Timed <input type="checkbox"/> Crea Clearance, 24 hr (CRCL) Height _____ cm Weight _____ kg Drugs <input type="checkbox"/> Acetaminophen (ACTM) <input type="checkbox"/> Ethanol (ETOH) <input type="checkbox"/> Salicylate Therapeutic Monitoring Dose Regimen _____ Route _____ Time on regimen _____ Last Dose _____ (date/time) _____ Next Dose _____ (date/time) _____ <input type="checkbox"/> Carbamazepine/Tegretol <input type="checkbox"/> Digoxin <input type="checkbox"/> Lithium <input type="checkbox"/> Phenobarbital (PHNO) <input type="checkbox"/> Phenytoin /Dilantin (PTN) <input type="checkbox"/> Theophylline <input type="checkbox"/> Valproate/Depakene Electrocardiogram <input type="checkbox"/> ECG To be read by _____ Reason: _____	
Enzymes <input type="checkbox"/> ALP <input type="checkbox"/> ALT <input type="checkbox"/> AST <input type="checkbox"/> CK <input type="checkbox"/> GGT <input type="checkbox"/> LD <input type="checkbox"/> Lipase <input type="checkbox"/> Troponin	Proteins <input type="checkbox"/> Albumin <input type="checkbox"/> C3 Complement <input type="checkbox"/> C4 Complement <input type="checkbox"/> C-Reactive Protein (CRP) Cardiac? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Immunoglobulin Panel (IgQ) <input type="checkbox"/> Protein Electrophoresis (PE) <input type="checkbox"/> Protein, Total	Pregnancy Prenatal Screen: Use AB Gov't Requisition <input type="checkbox"/> HCG Urine <input type="checkbox"/> HCG Serum <input type="checkbox"/> Gestational Diabetes Screen (GDS) <input type="checkbox"/> Gestational 2 hr glucose tolerance (F) (GLUT2)	Other Specimens / Fluids <input type="checkbox"/> FIT Colorectal CA Screen <input type="checkbox"/> Semen, Post-Vas (SMNPV) Sterile Body Fluid <input type="checkbox"/> Synovial <input type="checkbox"/> Other _____ <input type="checkbox"/> CSF (Phone lab if CJD Risk) Source: _____ Tests: _____	Other Tests/Comments