

# PHSA Laboratories

BC Centre for Disease Control

## PUBLIC HEALTH TEST REQUISITION – SEROLOGY SCREENING

Lack of / or unclear information provided on this requisition may result in delay or a failure to process specimens.  
PHSA Laboratories does not assume any liability for unlabelled specimens

### Section 1 – Patient and Physician Information

*Personal Health Number		*Ordering Physician /Billing # or Agency / ID #:	
*Patient Surname	*First Name, Second Name	*Locum For:	
*DOB: DD/MMM/YYYY	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK	*Address for Report Delivery:	
Address		Copy Results To: 1. 2. 3.	
City / Town	Postal Code		
Submitter's Reference #	*Collection Facility Code		
*Date/ Time of Collection: DD/MMM/YYYY / HH:MM			

### Section 2 – Clinical Information

<b>Clinical Information</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Gastrointestinal Symptoms <input type="checkbox"/> Headache / Stiff Neck <input type="checkbox"/> Respiratory Symptoms <input type="checkbox"/> Rash Symptoms <input type="checkbox"/> STD Contact <input type="checkbox"/> STD Symptoms <input type="checkbox"/> Fever <input type="checkbox"/> Other (Specify): _____		<b>Reason for Test</b> <input type="checkbox"/> Therapeutic Monitoring <input type="checkbox"/> NEEDLESTICK <input type="checkbox"/> Immigration <input type="checkbox"/> Acute <input type="checkbox"/> Prenatal <input type="checkbox"/> Convalescent <input type="checkbox"/> Follow-up <input type="checkbox"/> Outbreak/Cluster/Event <input type="checkbox"/> Other (Specify): _____	
Recent Travel (Date/Location)	Onset Date DD/MMM/YYYY	History	

### Section 3 – Test Requested (Note: Codes For PHSA Labs Use Only)

<b>HIV (Non Prenatal)</b> <u>Note: Patient has legal right to choose nominal or non-nominal reporting of Positive HIV to MHO</u>  HIV Nominal Reporting <input type="checkbox"/> HIV HIV Non-Nominal Reporting <input type="checkbox"/> HIV	<b>SYPHILIS (Non Prenatal)</b> Syphilis Screen <input type="checkbox"/> TPS Syphilis Confirmatory <input type="checkbox"/> TPSC <b>(NOTE : HISTORY REQUIRED FOR CONFIRMATORY TEST)</b>	<b>PRENATAL SCREENING</b> HIV Nominal Reporting <input type="checkbox"/> HIV      HIV Non-Nominal Reporting <input type="checkbox"/> HIV HBsAg <input type="checkbox"/> HBVP      Syphilis Screen <input type="checkbox"/> TPS Rubella IgG <input type="checkbox"/> RUBIG      Other (Specify): _____  *EDC:      *Hospital of Delivery:	
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<b>HEPATITIS</b> <b>Chronic - undefined etiology</b> HBsAg, Anti-HBcTotal <input type="checkbox"/> HBVSAG Anti-HBs, Anti-HCV <input type="checkbox"/> HEPC  <b>Specific Hepatitis Markers</b> Anti-hepatitis A Total (Immune Status) <input type="checkbox"/> HAVT Anti-HBs (Immune Status) <input type="checkbox"/> HBVSAB Anti-HBcTotal (Natural Infection) <input type="checkbox"/> HBCT HBeAg (Therapeutic Monitoring) <input type="checkbox"/> HEBEAG	<b>Acute - undefined etiology</b> HBsAg, Anti-HBcTotal, Anti-HBs, Anti-HCV, Anti-HAV-IgM <input type="checkbox"/> HEPS Anti-hepatitis A IgM (Acute Infection) <input type="checkbox"/> HAVIM HBsAg (Active Infection) <input type="checkbox"/> HBVT Anti-HBc-IgM (Acute Infection) <input type="checkbox"/> HBCIM Anti-HCV <input type="checkbox"/> HEPC	<b>OTHER SEROLOGY</b> <table border="0"> <tr> <th>Immunity</th> <th>Acute</th> </tr> <tr> <td>Measles IgG (Rubeola) <input type="checkbox"/> MIG</td> <td>Measles IgM (Rubeola) <input type="checkbox"/> MIM</td> </tr> <tr> <td>Mumps IgG <input type="checkbox"/> MUIG</td> <td>Mumps IgM <input type="checkbox"/> MUIM</td> </tr> <tr> <td>Parvo B19 IgG <input type="checkbox"/> PARVG</td> <td>Parvo B19 IgM <input type="checkbox"/> PARVM</td> </tr> <tr> <td>Rubella IgG <input type="checkbox"/> RUBIG</td> <td>Rubella IgM <input type="checkbox"/> RUBIM</td> </tr> <tr> <td>EBV IgG <input type="checkbox"/> EBGS</td> <td>EBV IgM <input type="checkbox"/> EBGM</td> </tr> <tr> <td>CMV IgG <input type="checkbox"/> CMVIG</td> <td>CMV IgM <input type="checkbox"/> CMVIM</td> </tr> <tr> <td>VZ IgG (Immune Status) <input type="checkbox"/> VZIG</td> <td>HTLV I/II <input type="checkbox"/> AHTLV</td> </tr> <tr> <td>H. pylori <input type="checkbox"/> HPGS</td> <td>Mycoplasma <input type="checkbox"/> MPIM</td> </tr> <tr> <td>HSV IgG <input type="checkbox"/> HSVIG</td> <td></td> </tr> </table>		Immunity	Acute	Measles IgG (Rubeola) <input type="checkbox"/> MIG	Measles IgM (Rubeola) <input type="checkbox"/> MIM	Mumps IgG <input type="checkbox"/> MUIG	Mumps IgM <input type="checkbox"/> MUIM	Parvo B19 IgG <input type="checkbox"/> PARVG	Parvo B19 IgM <input type="checkbox"/> PARVM	Rubella IgG <input type="checkbox"/> RUBIG	Rubella IgM <input type="checkbox"/> RUBIM	EBV IgG <input type="checkbox"/> EBGS	EBV IgM <input type="checkbox"/> EBGM	CMV IgG <input type="checkbox"/> CMVIG	CMV IgM <input type="checkbox"/> CMVIM	VZ IgG (Immune Status) <input type="checkbox"/> VZIG	HTLV I/II <input type="checkbox"/> AHTLV	H. pylori <input type="checkbox"/> HPGS	Mycoplasma <input type="checkbox"/> MPIM	HSV IgG <input type="checkbox"/> HSVIG	
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H. pylori <input type="checkbox"/> HPGS	Mycoplasma <input type="checkbox"/> MPIM																						
HSV IgG <input type="checkbox"/> HSVIG																							
<b>OTHER TESTS</b>		<b>*SIGNATURE</b>																					

**THE NUMBER OF TUBES OF BLOOD REQUIRED**

**NOTE:**  
STAT TESTING MUST BE CLEARLY INDICATED ON FRONT OF REQUISITION.

**NOTE:**  
THE PROPER VACUTAINER FOR COLLECTION OF BLOOD IS THE BD VACUTAINER SST, REF 367986 (GOLD TOP).

**SYPHILIS REQUIRES 1 TUBE OF BLOOD**

**HIV REQUIRES 1 TUBE OF BLOOD**

**PRENATAL SCREEN REQUIRES 2 TUBES OF BLOOD**

**ANY COMBINATION OF HEPATITIS MARKER REQUIRES 1 TUBE OF BLOOD**

**H. PYLORI REQUIRES 1 TUBE OF BLOOD**

**ANY COMBINATION OF OTHER SEROLOGY TESTS REQUESTED FROM THIS LIST REQUIRES 1 TUBE OF BLOOD (eg. MUMPS, MEASLES, RUBELLA ETC.)**

**\*KEY FIELDS THAT MUST BE FILLED (Non-nominal testing, may use initials only - no PHN)**

**PHSA Laboratories**  
DC Centre for Disease Control

**PUBLIC HEALTH TEST REQUISITION - SEROLOGY SCREENING**  
Level of Care: *For further information provided on this requisition may result in delay or a failure to process specimens. PHSA Laboratories does not assume any liability for uncollected specimens.*

*Personal Health Number		*Collection Provided on: <input type="checkbox"/> Nursing / <input type="checkbox"/> Agency / <input type="checkbox"/> Home	
*Patient Surname	*First Name, Second Name	*Locum For:	
*DOB: DDMMYYYY	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> USA	*Address for Report Delivery:	
Address		City/Town	
Postal Code		Copy Results To:	
*Collector's Reference #	*Collection Facility Code	1.	
*Date/Time of Collection: DDMMYYYY/HHMM		2.	
		3.	
<b>Clinical Information</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Headache / Still Neck <input type="checkbox"/> Rash Symptoms <input type="checkbox"/> Fever <input type="checkbox"/> Gastrointestinal Symptoms <input type="checkbox"/> Respiratory Symptoms <input type="checkbox"/> STD Contact <input type="checkbox"/> Other (Specify)		<b>Reason for Test</b> <input type="checkbox"/> Therapeutic Monitoring <input type="checkbox"/> Investigation <input type="checkbox"/> Prenatal <input type="checkbox"/> Follow Up <input type="checkbox"/> NEEDLESTICK <input type="checkbox"/> Abuse <input type="checkbox"/> Contact <input type="checkbox"/> Outbreak/Cluster/Event <input type="checkbox"/> Other (Specify)	
*Recent Travel (Date/Location)	*Onset Date: DDMMYYYY	*History	
<b>HIV (Non Prenatal)</b> Note: Patient has legal rights to choose method or frequency of reporting of Positive HIV-1 RNA HIV RNA Reporting: <input type="checkbox"/> <input type="checkbox"/> HIV Non-RNA Reporting: <input type="checkbox"/> <input type="checkbox"/>	<b>SYPHILIS (Non Prenatal)</b> Syphilis Serology: <input type="checkbox"/> <input type="checkbox"/> Syphilis Cardiology: <input type="checkbox"/> <input type="checkbox"/> <b>NOTE - HISTORY REQUIRED FOR COMBINATION TESTS</b>	<b>PRENATAL SCREENING</b> HIV Non-RNA Reporting: <input type="checkbox"/> <input type="checkbox"/> HIV RNA Reporting: <input type="checkbox"/> <input type="checkbox"/> Rubella IgG: <input type="checkbox"/> <input type="checkbox"/> Other (Specify): <input type="checkbox"/>	
<b>HEPATITIS</b> Chronic - undiagnosed study: HBsAg, Anti-HBc Total, Anti-HBc, Anti-HCV Acute - undiagnosed study: HBsAg, Anti-HBc Total, Anti-HBc, Anti-HAV IgM Specific Hepatitis Markers: Anti-Hepatitis A Total (serologic status), Anti-HBc (immune status), Anti-HBc IgM (acute infection), HBsAg (Therapeutic Monitoring), Anti-HCV		<b>OTHER SEROLOGY</b> Measles IgG (Rubella), Mumps IgG, Parvo D19 IgG, Rubella IgG, EBV IgG, CMV IgG, VZ IgG (varicella zoster), H. pylori, HSV IgG Measles IgM (Rubella), Mumps IgM, Parvo D19 IgM, Rubella IgM, EBV IgM, CMV IgM, HTLV I/II, Mycoplasma	
<b>OTHER TESTS</b> For information on specimen collection including pediatric volumes, please see Manual of Services at <a href="http://www.bccdc.org/content.php?item=322">http://www.bccdc.org/content.php?item=322</a> or call 1 877 PHSA LAB.		Form PPHS-100-001 Version 2.0 2007/MAR 00073506	

**NOTE: COLLECTION FACILITY CODE IS MANDATORY EXCEPT FOR PUBLIC HEALTH WORKERS AND THE UNITS IN WHICH THEY WORK. YOU CAN OBTAIN YOUR COLLECTION FACILITY CODE THROUGH THE MSP TELEPLAN UNDER "OTHER PROCESSING OPTIONS".**