Newfoundland Labrador

Outpatient Specimen Collection Requisition

HCN:_____ Prov/Terr:____ Expiry:____/____/____
YYYY MON DD

Full Legal Name First Middle Surname

DOB:____/____/____ (YYYY/MON/DD) Sex: ☐ M ☐ F ☐ UN

Mailing Address:_____

City: _____ Prov: _____ Postal Code:_ _ _ _ _ _

Telephone: (Check Best) ☐ Home (_ _ _) - _ _ _ - _ _ _ _

☐ Cell (_ _ _) -_ _ _-_ _ _ _ ☐ Work (_ _ _) - _ _ _ - _ _ _ _

Ordering Provider's Name:_____

Clinic Name: _____

Mailing Address:_____

City:_____ Prov: _____ Postal Code: _ _ _ _ _ _

Phone: (_ _ _) -_ _ _- _ _ _ _ Fax: (_ _ _) -_ _ _- _ _ _ _

Ordering Provider's Meditech Mnemonic:_____

Signature:_____Date:_____ / _____ / ___
YYYY MON DD

Clinic Stamp:(include fax, provider and mnemonics)

EMR Clinic Mnemonic:_____

COPY TO PROVIDER _____

DIAGNOSIS / RELEVANT HISTORY

_____

_____

_____

_____

Frequency of Testing (For Repeat Testing)_____

THERAPEUTIC DRUG MONITORING

☐ Drug #1:

Date and Time of **Last** Dose: _____ / _____ / ___ ___ : ___

Date and Time of **Next** Dose: _____/ _____ / ___ ___ : ___
YYYY MON DD HH MM

☐ Drug #2:

Date and Time of Last Dose: _____ / _____ / ___ ___ : ___

Date and Time of Next Dose: _____ / _____ / ___ ___ : ___
YYYY MON DD HH MM

URINE TESTING Antibiotics: _____

- ☐ URINAP…….Urinalysis (reflex microscopic when applicable)
- ☐ HCGU…….Pregnancy Test
- ☐ URINCU…….Urine Culture ☐ Symptomatic ☐ Pregnant
  (Urine cultures collected from indwelling catheters will be rejected)
- ☐ MALCRPU….Albumin/Creatinine Ratio (Microalbumin)

PRENATAL SCREENING

- ☐ BLTYABS ….Type and Screen
- ☐ PNS……Prenatal Serology (Includes HIV, Rubella, HBSAG, Syphilis Screen)

MICROBIOLOGY

- ☐ HIVS……..HIV Screen ☐ HBSAB…..Hep B Immunity Screen
- ☐ TPALAB……Syphilis Screen
- ☐ CTNGDP….CT/NG Testing (Swab)
- ☐ CTNGDPU..CT/NG Testing (Urine)
- ☐ HEPDX……..Hepatitis Diagnosis Panel
  (HAV IgM, HBV surface Ag, anti-HBV core total, anti-HCV)

ADDITIONAL REQUESTS: (MUST BE PRINTED LEGIBLY)

_____

_____

_____

_____

HEMATOLOGY

- ☐ CBC..... (Includes automated differential)
- ☐ PTI..... INR Anticoagulant _____

IMMUNOHEMATOLOGY

- ☐ BLTYABS.....Type and Screen

CHEMISTRY

- ☐ GLUFA ..... Glucose (Fast 8hr)
- ☐ GLUCO ..... Glucose – Random (Non-fasting)
- ☐ GTT2H ..... 75 gm OGTT (Fast 8hr)
- ☐ G1HP50GGO ..... 50 gm Prenatal Screen (Non-fasting)
- ☐ GTTG ..... 75 gm OGTT (Fast 8hr; for PRE-NATAL use)
- ☐ HBA1CTHB.. ..... Hemoglobin A1C
- ☐ CR ..... Creatinine (with eGFR)
- ☐ SODIU..... Sodium
- ☐ POTAS ..... Potassium
- ☐ BILTO..... Bilirubin, Total
- ☐ ALT ..... Alanine Aminotransferase
- ☐ CALCI ..... Calcium (with Albumin)
- ☐ URATE ..... Uric Acid
- ☐ PROTE..... Total Protein
- ☐ ALBUM..... Albumin
- ☐ CREKI ..... Creatine Kinase
- ☐ HEPFUP ..... ALP, ALT (Reflex AST & Total Bilirubin)
- ☐ LIPIDP..... TChol, HDL, TG, Calculated LDL, non-HDLC
- ☐ TSH ..... Thyroid Stimulating Hormone (Reflex fT4)
- ☐ CRPHS ..... C-Reactive Protein
- ☐ FERRI ..... Ferritin
- ☐ PSA.....Prostate Specific Antigen (PSA)

If fasting is required – do not eat anything (except medications and/or water) for the time period indicated.
If you need additional information about preparing for your lab test, please contact your local Laboratory Medicine services.

Please note, some tests require an accompanying completed Special Authorization form before the test order can proceed.

*DATE & TIME OF COLLECTION:_____/ _____ / ___ ___ : ___ INITIALS:_____
YYYY MON DD HH MM

Clear Form Print Form

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