

# Saint John Area General Requisition

\*\*All information MUST be legible\*\*

BACK

Mandatory Information	Patient's Last Name:				Complete MANDATORY information on both sides of requisition			
	First Name:				Relevant Clinical/Medication Information:			
	NB Medicare #:		Expiry Date:					
	If no NB Medicare # is present, Other Patient # and Address is required							
	DOB:	D	M	Y	Sex:			
Ordering Provider:	(First & last name, specialty,)			Copies To:	(First & last name, specialty)			

SERUM / PLASMA CHEMISTRY	URINE RANDOM <small>Collection time &amp; date must be on specimen container</small>																				
<input type="checkbox"/> A1C <input type="checkbox"/> ACTH+ <input type="checkbox"/> AFP <input type="checkbox"/> Albumin <input type="checkbox"/> Aldosterone <input type="checkbox"/> Alkaline Phosphatase <input type="checkbox"/> Alpha-1 Antitrypsin <input type="checkbox"/> ALT <input type="checkbox"/> Ammonia+ <input type="checkbox"/> ANCA <input type="checkbox"/> ACE <input type="checkbox"/> Acetaminophen <input type="checkbox"/> B12 <input type="checkbox"/> β-HCG (Quantitative) <input type="checkbox"/> B2 Microglobulin <input type="checkbox"/> Bicarbonate (TCO2) <input type="checkbox"/> Bilirubin Total <input type="checkbox"/> NT-proBNP <input type="checkbox"/> C1 Inhibitor+ <input type="checkbox"/> C3/C4 Complement <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Calcium <input type="checkbox"/> Calcium Ionized <input type="checkbox"/> Carbamazepine <input type="checkbox"/> CEA <input type="checkbox"/> Celiac Profile (tTG IgA) <input type="checkbox"/> Ceruloplasmin <input type="checkbox"/> CK <input type="checkbox"/> Cortisol Random <input type="checkbox"/> Cortisol AM <input type="checkbox"/> Cortisol PM	<input type="checkbox"/> C-Peptide* <input type="checkbox"/> Creatinine <input type="checkbox"/> CRP <input type="checkbox"/> Cryoglobulin**+ <input type="checkbox"/> Cyclosporin <input type="checkbox"/> Digoxin <input type="checkbox"/> Electrolytes (Na, K, Cl) <input type="checkbox"/> Estradiol <input type="checkbox"/> Ferritin <input type="checkbox"/> Folate* <input type="checkbox"/> FSH <input type="checkbox"/> GBM <input type="checkbox"/> Gentamicin Random <input type="checkbox"/> Gentamicin Peak <input type="checkbox"/> Gentamicin Trough <input type="checkbox"/> Glucose Fast* <input type="checkbox"/> Glucose Random <input type="checkbox"/> Growth Hormone+ <input type="checkbox"/> Haptoglobin <input type="checkbox"/> Homocysteine+ <input type="checkbox"/> IgE <input type="checkbox"/> IGF-1 <input type="checkbox"/> Insulin Fasting* <input type="checkbox"/> Iron Panel (Fe, IBC, Sat, Ferritin Ferritin)* <input type="checkbox"/> Lactate+ <input type="checkbox"/> LDH <input type="checkbox"/> Lead (whole blood) <input type="checkbox"/> LH <input type="checkbox"/> Lipase																				
<input type="checkbox"/> Lipid Profile-Fasting** <input type="checkbox"/> Lipid Profile- Non-Fasting <input type="checkbox"/> Lithium <input type="checkbox"/> Magnesium <input type="checkbox"/> Methotrexate+ <input type="checkbox"/> Osmolality <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Phenytoin <input type="checkbox"/> Phosphate <input type="checkbox"/> Prealbumin <input type="checkbox"/> Prolactin <input type="checkbox"/> Protein Electrophoresis <input type="checkbox"/> Protein Total <input type="checkbox"/> PSA Total <input type="checkbox"/> PTH <input type="checkbox"/> Renin+ <input type="checkbox"/> Rheumatoid Factor <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Testosterone <input type="checkbox"/> Testosterone Bioavailable <input type="checkbox"/> Theophylline <input type="checkbox"/> Tobramycin <input type="checkbox"/> Total Bile Acids* <input type="checkbox"/> TSH (with reflex to FT4) <input type="checkbox"/> tTG Ab <input type="checkbox"/> Urea <input type="checkbox"/> Uric Acid <input type="checkbox"/> Valproate <input type="checkbox"/> Vancomycin <input type="checkbox"/> Vitamin D (25-OH)	<input type="checkbox"/> Urinalysis Routine <input type="checkbox"/> Urine C&S: <input type="checkbox"/> MSU/Clean Catch <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Other: <input type="checkbox"/> β-HCG (qualitative)																				
<b>24 HOUR URINE</b> <small>Collection time &amp; date must be on specimen container</small>																					
<input type="checkbox"/> Full Methadone Panel <input type="checkbox"/> Amphetamines <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepenes <input type="checkbox"/> Opiates <input type="checkbox"/> Methadone metabolite <input type="checkbox"/> Oxycodone <input type="checkbox"/> Abuse Screen- Urine <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepenes <input type="checkbox"/> Amphetamines <input type="checkbox"/> Ethanol <input type="checkbox"/> Oxycodone <input type="checkbox"/> Opiates <input type="checkbox"/> Methadone metabolite	<input type="checkbox"/> Albumin/Creatinine Ratio <input type="checkbox"/> Protein/Creatinine Ratio <input type="checkbox"/> Protein Electrophoresis <input type="checkbox"/> Urine Electrolytes <input type="checkbox"/> GC & Chlamydia Screen (first void) <input type="checkbox"/> Urine for TB (first void)																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">STOOL and SPUTUM Specimens Collection time &amp; date must be on specimen container and requisition. These specimens are self-collected.</th> </tr> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Stool Culture  <input type="checkbox"/> Stool O&amp;P Exam  <input type="checkbox"/> Stool H. Pylori  <input type="checkbox"/> Stool Viral Testing                             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Sputum Culture  <input type="checkbox"/> Sputum TB Culture  <input type="checkbox"/> Sputum Fungal Culture                             </td> </tr> </table>		STOOL and SPUTUM Specimens Collection time & date must be on specimen container and requisition. These specimens are self-collected.		<input type="checkbox"/> Stool Culture <input type="checkbox"/> Stool O&P Exam <input type="checkbox"/> Stool H. Pylori <input type="checkbox"/> Stool Viral Testing	<input type="checkbox"/> Sputum Culture <input type="checkbox"/> Sputum TB Culture <input type="checkbox"/> Sputum Fungal Culture																
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\*8hrs fasting    \*\*12hrs fasting – Consume nothing by mouth during the fasting period. A small sip of water or ice is permissible /  
 \*8h jeune        \*\*12h jeune - Ne rein consommer oralement durant la période de jeune. Une petite gorge d'eau ou de glace est permise.

Tests with + are collected at SJRH only / Les tests avec le signe + sont collectés uniquement à SJRH



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FRONT

Appointment Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> STAT				<input type="checkbox"/> Non-insured: Horizon Staff <input type="checkbox"/> Non-insured: Private Practice				
Mandatory Information	Patient's Last Name:				Patient Location:			
	First Name:				Account #:			
	NB Medicare #:		Expiry Date:		Other Provincial Healthcare # & Province or Patient #:			
	If no NB Medicare # is present, Other Patient # and Address is required							
	DOB:	D	M	Y	Sex:		Address:	
Ordering Provider:	(First & last name, specialty,)			Province:		Postal Code:		
Copies To:	(First & last name, specialty)			Reoccurring Frequency:				
Relevant Clinical/ Medication Information:								
NOTE: Specimens <b>MUST</b> be labelled with patient's full name, Medicare number, date and time, Phlebotomist Identification								
Collection Date:				Time:		Collection Location:		
Collected By:				Full Signature*				

HAEMATOLOGY/ FLOW CYTOMETRY/ IMMUNOLOGY	MICROBIOLOGY	TRANSFUSION MEDICINE * This requisition MUST be signed with the first and last name of the phlebotomist and include the date and time of collection
<input type="checkbox"/> CBC and DIFF <input type="checkbox"/> Reticulocyte Count <input type="checkbox"/> ESR <input type="checkbox"/> D-Dimer <input type="checkbox"/> Mono Test <input type="checkbox"/> PT/INR <input type="checkbox"/> APTT <input type="checkbox"/> Platelet Function Screen <input type="checkbox"/> Fibrinogen <input type="checkbox"/> Immunocompetence Profile CD4 Count <input type="checkbox"/> Immunophenotyping	<input type="checkbox"/> ANA <input type="checkbox"/> ENA <input type="checkbox"/> CCP <input type="checkbox"/> DNA (dsDNA Antibody) <input type="checkbox"/> ACA <input type="checkbox"/> Beta-2 Glycoprotein 1 <input type="checkbox"/> Cytoplasmic antibodies (AMA, APCA, ASMA) <b>List anticoagulants:</b>	<input type="checkbox"/> Bloodborne Pathogen Panel (Syphilis, HBsAg, HIV screen, HCV) <input type="checkbox"/> Hepatitis B Surface Antigen (HBsAg) <input type="checkbox"/> Hepatitis B Surface Antibody (immune status) <input type="checkbox"/> Hepatitis C Antibody (HCV) <input type="checkbox"/> HIV 1,2 Antigen/Antibody Screen <input type="checkbox"/> Syphilis Serology <input type="checkbox"/> Hepatitis A IgM Antibody <input type="checkbox"/> Hepatitis A IgG Antibody <input type="checkbox"/> Total Hepatitis B Core Antibodies (IgG,IgM) <input type="checkbox"/> HCV Viral Load <input type="checkbox"/> HCV Viral Load and Genotype <input type="checkbox"/> HIV Viral Load <input type="checkbox"/> Hepatitis B Viral Load <input type="checkbox"/> IGRA <input type="checkbox"/> Serology IRCC Panel (HIV, HBsAg, AntiHBS, Syphilis)
<input type="checkbox"/> Prenatal routine serology:(Syphilis, Rubella IgG, HBsAg, HIV screen) <input type="checkbox"/> Prenatal Transfusion Medicine:(ABO, Rh, Antibody detection)		
<b>SPECIMEN COLLECTION CLINICS- Services are by APPOINTMENT ONLY. Please call ahead.</b> <b>COLLECTE D'ÉCHANTILLONS - Les services se font UNIQUEMENT SUR RENDES-VOUS. Veuillez appeler à l'avance.</b>		
Saint John Regional Hospital / Hôpital régional de Saint John St. Joseph's Hospital / Hôpital St. Joseph KV Health Services / Centre de santé de la VK Market Place Wellness / Centre de mieux-être Market Place Sussex Health Centre / Centre de santé de Sussex Charlotte County Hospital / Hôpital du comté de Charlotte	506-648-6681	Campobello Island Health Centre / Centre de santé de Campobello 506-752-4100
Hope Wellness Centre / Centre H.O.P.E.	506-632-5695	Deer Island Clinic / Centre de santé de Deer Island 506-747-4150
Fundy Health Centre / Centre de santé de Fundy	506-456-4200	Grand Manan Hospital / Hôpital de Grand Manan 506-662-4060
Other (Specify):		Ordering Provider's Stamp