

Appointment Priority:  Routine  Urgent  STAT  Non-insured: Horizon Staff  Non-insured: Private Practice

<b>Mandatory Information</b>	Patient's Last Name:				<b>Other Information</b>	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					Address:					
	DOB:	D	M	Y		Sex:		Province:			Postal Code:
	Ordering Provider:	(First & last name, specialty,)									
Copies To:	(First & last name, specialty)										
Relevant Clinical/ Medication Information:											

**NOTE: Specimens MUST 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"/> ABO, Rh, Antibody Detection <input type="checkbox"/> Pregnant within the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Transfusion in the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there a history of transfusion problems? Indicate: _____ Has the patient had any transplants <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____ <b>Blood Products</b> <input type="checkbox"/> Red Blood Cells- Number of units: _____ <input type="checkbox"/> Irradiation- Indication _____ <input type="checkbox"/> Platelets- Number of Units: _____ <input type="checkbox"/> Irradiation- Indication _____ <input type="checkbox"/> Other (specify): _____ Location of Transfusion: _____ Date/Time of Transfusion: _____ <input type="checkbox"/> Father's Blood-Mother's Name and Medicare Number: _____  <input type="checkbox"/> Cold Agglutinin titre <input type="checkbox"/> Direct Antiglobulin Test
<b>PRENATAL WORKUP</b>		
<input type="checkbox"/> Prenatal routine serology:(Syphilis, Rubella IgG, HBsAg, HIV screen) <input type="checkbox"/> Prenatal Transfusion Medicine:(ABO, Rh, Antibody detection)		

**SPECIMEN COLLECTION CLINICS**- Services are by APPOINTMENT ONLY. Please call ahead.  
**COLLECTE D'ÉCHANTILLONS** - Les services se font UNIQUEMENT SUR RENDES-VOUS. Veuillez appeler à l'avance.

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
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# 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:							
	NB Medicare #:			Expiry Date:	Relevant Clinical/Medication Information:			
	If no NB Medicare # is present, Other Patient # and Address is required							
	DOB:	D	M	Y				
Ordering Provider:	(First & last name, specialty)			Copies To:	(First & last name, specialty)			

SERUM / PLASMA CHEMISTRY	URINE RANDOM
	Collection time & date must be on specimen container

<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"/> DHEAs <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"/> Immunoglobulins <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"/> Thyroglobulin <input type="checkbox"/> Tobramycin <input type="checkbox"/> Total Bile Acids* <input type="checkbox"/> Transferrin <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)
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<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)	<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)
<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"/> MTD Panel- Urine <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepenes <input type="checkbox"/> Methadone metabolite <input type="checkbox"/> Oxycodone

24 HOUR URINE	24 HOUR URINE
	Collection time & date must be on specimen container

<input type="checkbox"/> Albumin <input type="checkbox"/> Calcium <input type="checkbox"/> Citrate <input type="checkbox"/> Cortisol <input type="checkbox"/> Creatinine <input type="checkbox"/> Oxalate <input type="checkbox"/> Phosphate	<input type="checkbox"/> Protein Total <input type="checkbox"/> Protein Electrophoresis <input type="checkbox"/> Urate (Uric Acid) <input type="checkbox"/> Electrolytes (Na, K, Cl) <input type="checkbox"/> Heavy Metals Screen (Includes Arsenic, Cadmium, Lead, Mercury) <input type="checkbox"/> Creatinine Clearance Collect blood & urine Height: (cm): _____ Weight: (kg): _____
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GLUCOSE TOLERANCE TESTING	STOOL and SPUTUM Specimens Collection time & date must be on specimen container and requisition. These specimens are self-collected.
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<input type="checkbox"/> Gestational Diabetes-Screen: Non-Fasting 50g drink (1hr post) <input type="checkbox"/> Gestational Diabetes-Diagnosis: 75g drink (Fasting, 1h & 2hr)* <input type="checkbox"/> Diabetes Diagnosis: 75 g drink (Fasting, & 2 hr)*	<input type="checkbox"/> Stool Culture <input type="checkbox"/> Stool O&P Exam <input type="checkbox"/> Stool H. Pylori <input type="checkbox"/> Stool Viral Testing
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<input type="checkbox"/> OTHER: please indicate:
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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