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

SERUM / PLASMA CHEMISTRY

- ❒ A1C
- ❒ ACTH+
- ❒ AFP
- ❒ Albumin
- ❒ Aldosterone
- ❒ Alkaline Phosphatase
- ❒ Alpha-1 Antitrypsin
- ❒ ALT
- ❒ Ammonia+
- ❒ ANCA
- ❒ ACE
- ❒ Acetaminophen
- ❒ B12
- ❒ β-HCG (Quantitative)
- ❒ B2 Microglobulin
- ❒ Bicarbonate (TCO2)
- ❒ Bilirubin Total
- ❒ NT-proBNP
- ❒ C1 Inhibitor+
- ❒ C3/C4 Complement
- ❒ CA 125
- ❒ CA 15-3
- ❒ CA 19-9
- ❒ Calcium
- ❒ Calcium Ionized
- ❒ Carbamazepine
- ❒ CEA
- ❒ Celiac Profile (tTG IgA)
- ❒ Ceruloplasmin
- ❒ CK
- ❒ Cortisol Random
- ❒ Cortisol AM
- ❒ Cortisol PM
- ❒ C-Peptide*
- ❒ Creatinine
- ❒ CRP
- ❒ Cryoglobulin**+
- ❒ Cyclosporin
- ❒ DHEAs
- ❒ Digoxin
- ❒ Electrolytes (Na, K, Cl)
- ❒ Estradiol
- ❒ Ferritin
- ❒ Folate*
- ❒ FSH
- ❒ GBM
- ❒ Gentamicin Random
- ❒ Gentamicin Peak
- ❒ Gentamicin Trough
- ❒ Glucose Fast*
- ❒ Glucose Random
- ❒ Growth Hormone+
- ❒ Haptoglobin
- ❒ Homocysteine+
- ❒ Immunoglobulins
- ❒ IgE
- ❒ IGF-1
- ❒ Insulin Fasting*
- ❒ Iron Panel (Fe, IBC, Sat, Ferritin Ferritin)*
- ❒ Lactate+
- ❒ LDH
- ❒ Lead (whole blood)
- ❒ LH
- ❒ Lipase
- ❒ Lipid Profile-Fasting**
- ❒ Lipid Profile- Non-Fasting
- ❒ Lithium
- ❒ Magnesium
- ❒ Methotrexate+
- ❒ Osmolality
- ❒ Phenobarbital
- ❒ Phenytoin
- ❒ Phosphate
- ❒ Prealbumin
- ❒ Prolactin
- ❒ Protein Electrophoresis
- ❒ Protein Total
- ❒ PSA Total
- ❒ PTH
- ❒ Renin+
- ❒ Rheumatoid Factor
- ❒ Tacrolimus
- ❒ Testosterone
- ❒ Testosterone Bioavailable
- ❒ Theophylline
- ❒ Thyroglobulin
- ❒ Tobramycin
- ❒ Total Bile Acids*
- ❒ Transferrin
- ❒ TSH (with reflex to FT4)
- ❒ tTG Ab
- ❒ Urea
- ❒ Uric Acid
- ❒ Valproate
- ❒ Vancomycin
- ❒ Vitamin D (25-OH)

URINE RANDOM

Collection time & date must be on specimen container

- ❒ Urinalysis Routine
- ❒ Urine C&S:
  - ❒ MSU/Clean Catch
  - ❒ Foley Catheter
  - ❒ Other:
- ❒ β-HCG (qualitative)
- ❒ Albumin/Creatinine Ratio
- ❒ Protein/Creatinine Ratio
- ❒ Protein Electrophoresis
- ❒ Urine Electrolytes
- ❒ GC & Chlamydia Screen (first void)
- ❒ Urine for TB (first void)

- ❒ Full Methadone Panel
  - ❒ Amphetamines
  - ❒ Cocaine
  - ❒ Benzodiapenes
  - ❒ Opiates
  - ❒ Methadone metabolite
  - ❒ Oxycodone
- ❒ MTD Panel- Urine
  - ❒ Cocaine
  - ❒ Benzodiapenes
  - ❒ Opiates
  - ❒ Methadone metabolite
  - ❒ Oxycodone
- ❒ Abuse Screen- Urine
  - ❒ Cocaine
  - ❒ Benzodiapenes
  - ❒ Amphetamines
  - ❒ Ethanol
  - ❒ Oxycodone
  - ❒ Opiates
  - ❒ Methadone metabolite

24 HOUR URINE

Collection time & date must be on specimen container

- ❒ Albumin
- ❒ Calcium
- ❒ Citrate
- ❒ Cortisol
- ❒ Creatinine
- ❒ Oxalate
- ❒ Phosphate
- ❒ Protein Total
- ❒ Protein Electrophoresis
- ❒ Urate (Uric Acid)
- ❒ Electrolytes (Na, K, Cl)
- ❒ Heavy Metals Screen (Includes Arsenic, Cadmium, Lead, Mercury)
- ❒ Creatinine Clearance

Collect blood & urine

Height: (cm): _____

Weight: (kg): _____

GLUCOSE TOLERANCE TESTING

- ❒ Gestational Diabetes-Screen: Non-Fasting 50g drink (1hr post)
- ❒ Gestational Diabetes-Diagnosis: 75g drink (Fasting, 1h & 2hr)*
- ❒ Diabetes Diagnosis: 75 g drink (Fasting, & 2 hr)*

STOOL and SPUTUM Specimens

Collection time & date must be on specimen container and requisition. These specimens are self-collected.

- ❒ Stool Culture
- ❒ Stool O&P Exam
- ❒ Stool H. Pylori
- ❒ Stool Viral Testing
- ❒ Sputum Culture
- ❒ Sputum TB Culture
- ❒ Sputum Fungal Culture

❒ **OTHER: please indicate:**

***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

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Saint John Area General Requisition

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FRONT

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

Mandatory Information					Other Information
Patient's Last Name:					Patient Location:
First Name:					Account #:
NB Medicare #: (If no NB Medicare # is present, Other Patient # and Address is required)				Expiry Date:	Other Provincial Healthcare # & Province or Patient #:
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 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

- ❒ CBC and DIFF
- ❒ Reticulocyte Count
- ❒ ESR
- ❒ D-Dimer
- ❒ Mono Test
- ❒ PT/INR
- ❒ APTT
- ❒ Platelet Function Screen
- ❒ Fibrinogen
- ❒ Immunocompetence Profile CD4 Count
- ❒ Immunophenotyping
- ❒ ANA
- ❒ ENA
- ❒ CCP
- ❒ DNA (dsDNA Antibody)
- ❒ ACA
- ❒ Beta-2 Glycoprotein 1
- ❒ Cytoplasmic antibodies (AMA, APCA, ASMA)

List anticoagulants:

PRENATAL WORKUP

- ❒ Prenatal routine serology:(Syphilis, Rubella IgG, HBsAg, HIV screen)
- ❒ Prenatal Transfusion Medicine:(ABO, Rh, Antibody detection)

MICROBIOLOGY

- ❒ Bloodborne Pathogen Panel (Syphilis, HBsAg, HIV screen, HCV)
- ❒ Hepatitis B Surface Antigen (HBsAg)
- ❒ Hepatitis B Surface Antibody (immune status)
- ❒ Hepatitis C Antibody (HCV)
- ❒ HIV 1,2 Antigen/Antibody Screen
- ❒ Syphilis Serology
- ❒ Hepatitis A IgM Antibody
- ❒ Hepatitis A IgG Antibody
- ❒ Total Hepatitis B Core Antibodies (IgG,IgM)
- ❒ HCV Viral Load
- ❒ HCV Viral Load and Genotype
- ❒ HIV Viral Load
- ❒ Hepatitis B Viral Load
- ❒ IGRA
- ❒ Serology IRCC Panel (HIV, HBsAg, AntiHBS, Syphilis)

TRANSFUSION MEDICINE

*** This requisition MUST be signed with the first and last name of the phlebotomist and include the date and time of collection**

- ❒ ABO, Rh, Antibody Detection
  - ❒ Pregnant within the last 3 months ❒ Yes ❒ No
  - ❒ Transfusion in the last 3 months ❒ Yes ❒ No

If yes, is there a history of transfusion problems?
Indicate:_____

Has the patient had any transplants ❒ Yes ❒ No

If yes, specify:_____

Blood Products

- ❒ Red Blood Cells- Number of units: _____
  - ❒ Irradiation- Indication _____
- ❒ Platelets- Number of Units: _____
  - ❒ Irradiation- Indication_____
- ❒ Other (specify): _____

Location of Transfusion:_____

Date/Time of Transfusion:_____

- ❒ Father's Blood-Mother's Name and Medicare Number: _____
- ❒ Cold Agglutinin titre
- ❒ Direct Antiglobulin Test

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

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 Hospita l/ 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