SER

BC Centre for Disease Control
An agency of the Provincial Health Services Authority

# Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

## Serology Screening Requisition

SER LM LABS

## Section 1 - Patient/Provider Information *(Two matching unique patient identifiers on sample container and requisition are required for sample processing)*

**PERSONAL HEALTH NUMBER**
(or out-of province Health Number and province)

**PATIENT SURNAME**

**PATIENT FIRST AND MIDDLE NAME**

**DOB**
(DD/MMM/YYYY)

**SEX**
M ☐ F ☐ X ☐ U (Unk) ☐

**PATIENT ADDRESS**

**CITY**

**PROVINCE**

**POSTAL CODE**

**ORDERING PRACTITIONER**
Name and MSC#

**Address of report delivery**

☐ **I do not require a copy of the report** ☐ **I am a Locum**†
†If Locum, include name of Practitioner you are covering for

**ADDITIONAL COPIES TO PRACTITIONER / CLINIC:**
(Name, Address / MSC#/ PHSA Client#) **(Limit of 3 copies available)**
1.
2.
3.

DATE RECEIVED

**LABORATORY USE ONLY**

OUTBREAK ID

**SAMPLE REF. NO.**

**DATE COLLECTED**
(DD/MMM/YYYY)

**TIME COLLECTED**
(HH:MM)

## Section 2 - Clinical Information

**Reason for Test**

☐ **NEEDLESTICK**
☐ Outbreak/Cluster/Event
☐ Prenatal
☐ Other, specify: .....
.....

**Clinical Information**

☐ Rash symptoms ☐ STI contact ☐ STI symptoms

**Recent Travel History** (Date/Location)

**Onset Date** (DD/MMM/YYYY)

## Section 3 - Test(s) Requested (Note: Codes for PHSA Labs Use Only)

### PRENATAL SCREENING
(PRENAT)

| | |
|---|---|
| HIV | ☐ HIVCC |
| HIV Non-Nominal Reporting | ☐ HIVCC |
| HBsAg | ☐ HBVP |
| Rubella IgG | ☐ RUBEB |
| Syphilis Antibody (1st Trimester) | ☐ TPE |

Other Tests, specify:
.....
.....

### PERINATAL SYPHILIS

| | |
|---|---|
| Perinatal (>35 weeks/at delivery) | ☐ PDSYP |

### SYPHILIS ANTIBODY

| | |
|---|---|
| Routine (Non Prenatal) | ☐ TPE |

### HIV (Non Prenatal)

| | |
|---|---|
| HIV | ☐ HIVCC |

**Note: Patient has the legal right to choose not to have their name reported to public health = non-nominal reporting**

| | |
|---|---|
| Non-Nominal Reporting Requested | ☐ HIVCC |

### HEPATITIS SEROLOGY
(Serum)

| | |
|---|---|
| **Acute - undefined etiology** HBsAg, Anti-HBc Total, Anti-HBs, Anti-HCV, Anti-HAV IgM | ☐ HEPSB |
| **Chronic - undefined etiology** HBsAg, Anti-HBc Total Anti-HBs, Anti-HCV | ☐ DHEPCH |
| **Hepatitis B Screen Panel** HBsAg, Anti-HBs, Anti-HBc Total | ☐ HBSAG |
| Anti-hepatitis A Total (Immune Status) | ☐ HAAT |
| Anti-hepatitis A IgM (Acute Infection) | ☐ HAVMB |
| HBsAg Only | ☐ HBVSA |
| Anti-HBs (Immune Status) | ☐ HBSAB |
| HBeAg (Therapeutic Monitoring) | ☐ HBXEA |
| Anti-HBe (Therapeutic Monitoring) | ☐ HBXEB |
| Anti-HCV | ☐ HEPCB |

### HEPATITIS C PCR
(EDTA Plasma)

| | |
|---|---|
| HCV RNA Quantitative (For diagnosis and monitoring) | ☐ HPCRBB |
| HCV Genotyping (For treatment) | ☐ HEPCRB |

### OTHER SEROLOGY

| Immunity | | Acute | |
|---|---|---|---|
| CMV IgG | ☐ CMVIGB | CMV IgM | ☐ CMVSP |
| EBV IgG | ☐ EBGSB | EBV IgM | ☐ EBVSP |
| Measles IgG (Rubeola) | ☐ MIGB | Measles IgM (Rubeola) | ☐ MEASP |
| Mumps IgG | ☐ MUIGB | Mumps IgM | ☐ MUMPS |
| Parvo B19 IgG | ☐ PARVGB | Parvo B19 IgM | ☐ PARVP |
| Rubella IgG | ☐ RUBEB | Rubella IgM | ☐ RUBP |
| Toxo IgG | ☐ TOXGSB | Toxo IgM | ☐ TOXMSB |
| Varicella IgG | ☐ VZIGB | | |
| *H. pylori* IgG | ☐ HELIB | HSV Type Specific IgG | ☐ HSVTSS |
| HTLV I / II | ☐ HTLVB | | |

### OTHER TESTS (Specify)

For other available tests and sample collection information, consult the Public Health Laboratory's *eLab Handbook* at www.elabhandbook.info/PHSA/Default.aspx

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.

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## 1 - Patient/Provider Information

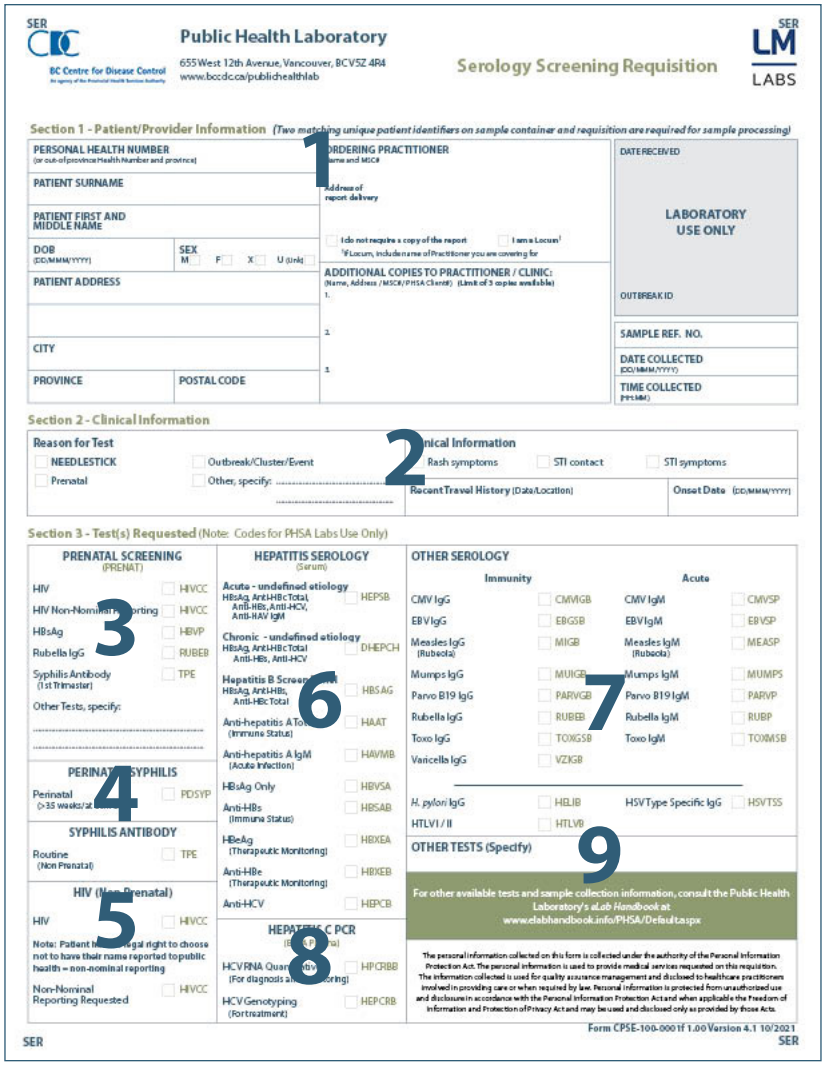
For physicians who work at more than one location, please provide an address for delivery.

### - Additional Copies To

The Ordering Physician will receive one copy of the report. Each physician or client listed under Additional Copies To: will receive a copy of the report.

## 2 - Clinical Information

Please fill in as completely as possible.




## 3 - Prenatal Testing*

-If nominal HIV testing, please provide 2 serum separator tubes.
-If non-nominal HIV testing, please provide 3 serum separator tubes.

## 4 - Perinatal Testing (Syphilis only)

-Please provide 1 serum separator tube.

## 5 - HIV Testing*

-If nominal HIV testing, please provide 1 serum separator tube.
-If non-nominal HIV testing, please provide 2 serum separator tubes.

## 6 - Hepatitis Serology Testing

-Please provide 1 serum separator tube.

## 7 - Combinations of Syphilis, nominal HIV, Hepatitis Serology and Other Serology

-Please provide 1 serum separator tube.
-If non-nominal reporting for HIV* is requested, please provide an additional serum separator tube (2 tubes in total).

## 8 - Hepatitis C PCR Testing

- For HCV RNA and HCV genotyping requests, please provide 1 EDTA plasma (lavender-top) tube.

## 9 - Other Tests

-Indicate all additional tests requested. Please consult the PHSA Laboratories eLab Handbook for specimen requirements.

**Form CPSE-100-0001f 1.00 Version 4.1 09/2021**

*Note for HIV patient has the legal right to choose not to have their name reported to public health.