Newfoundland Labrador

IV1820 0177 07 2018

HCN: _____

Province/Territory: _____ Expiry: _____

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ UN

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____

Telephone: (indicate preferred) ☐ Home: _____

☐ Cell: _____ ☐ Work: _____

# Outpatient Specimen Collection Requisition

Ordering Provider's Name: _____

Clinic's Name: _____

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____

Telephone: _____ Fax: _____

Signature: _____ Date: YYYY/MON/DD

**Clinic Stamp**:(include Fax, Provider and Mnemonics)

Ordering Provider's Meditech Mnemonic: _____

EMR Clinic Mnemonic: _____

COPY TO PROVIDER:

**DIAGNOSIS/RELEVANT HISTORY:**

**HEMATOLOGY**

☐ CBC (Includes automated differential)
☐ PTI INR Anticoagulant: _____

**IMMUNOHEMATOLOGY**

☐ BLTYABS Type and Screen

**CHEMISTRY**

☐ GLUFA Glucose (fast 8 hours)
☐ GLUCO Glucose – Random (non-fasting)
☐ GTT2H 75 gm OGTT (fast 8 hours)
☐ G1HP50GGO 50 gm Glucose (non-Fasting)
☐ GTTG 75 gm OGTT (fast 8 hours for PRE-NATAL use)
☐ HBA1CTHB Hemoglobin A1C
☐ EGFR 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 and 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)

Frequency of Testing (for repeat testing): _____

**THERAPEUTIC DRUG MONITORING**

☐ Drug #1
Date and Time of Last Dose: YYYY/MON/DD HH:MM
Date and Time of Next Dose: YYYY/MON/DD HH:MM
☐ Drug #2
Date and Time of Last Dose: YYYY/MON/DD HH:MM
Date and Time of Next Dose: YYYY/MON/DD HH:MM

**URINE TESTING**

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

**PRENATAL SCREENING**

☐ BLTYABS Type and Screen
☐ PNS Prenatal Screen (Includes CBC, HIV, Rubella, HBSAG, Syphilis Screen)

**MICROBIOLOGY**

☐ HIVS HIV Screen
☐ TPALAB Syphilis Screen
☐ CTNGDP CT/NG Testing (Swab)
☐ CTNGDPU CT/NG Testing (Urine)
☐ HEPDX Hepatitis Diagnosis/Screening Panel (B and C)
☐ HAVABM Acute Hepatitis A Testing
☐ HBSAB Hepatitis B Immunity

**ADDITIONAL REQUESTS (MUST BE PRINTED LEGIBLY)**

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, contact your local Laboratory Medicine Services.
**Note:** Some tests require an accompanying completed Special Authorization form before the test can proceed.

**Date and Time of collection:** YYYY/MON/DD HH:MM Collector's Signature: _____

Collector's Notes:

R0001MAY24