

PHN/Health Care Number		Accession #		Routine Requisition Please complete testing ASAP		LABORATORY MEDICINE AND PATHOLOGY Client Response Centre (780) 407-7484 CAPITAL HEALTH REGION LABORATORIES DYNALIFE DIAGNOSTIC LABORATORY SERVICES	
Sex	Patient Legal Name (Last) (First) (Initial)			DOB	Full Name & Location MUST BE PROVIDED		
Address City Province Postal Code				<input checked="" type="checkbox"/> Copy to Name: Phys Code: Address: . . .			
Chart #	Patient Phone #	Lab #		Ordering Physician / Practitioner Physician Code Specimen Event Type IA <input type="checkbox"/> AUXILIARY IP <input type="checkbox"/> IN PT OP <input type="checkbox"/> OUT PT AP <input type="checkbox"/> AMBUL HC <input type="checkbox"/> HMCARE ST <input type="checkbox"/> STAFF EN <input type="checkbox"/> ENVIRON WCB <input type="checkbox"/> Worker's Comp		Bill Type CPL <input type="checkbox"/> Alberta Health Care OR CC <input type="checkbox"/> Company OT <input type="checkbox"/> Out of Prov XX <input type="checkbox"/> Pre Paid PB <input type="checkbox"/> Patient Bill Co Name Address Client #	
Ordering Address / Location Zeidler Leducor Centre, University of Alberta, Edmonton		Report Location Code		Date specimen collected Col. Location SPECIMEN TYPE Blood <input type="checkbox"/> serum <input type="checkbox"/> plasma <input type="checkbox"/> whole blood <input type="checkbox"/> Microcollection Urine/Feces <input type="checkbox"/> Random <input type="checkbox"/> 24 h <input type="checkbox"/> Timed, other _____ Total Volume _____ Start date/time _____ Stop date/time _____ Diagnosis: _____ Other _____		HISTORY Inflammatory Bowel Disease	
TIME (24 h)		Collector		Fasting # of hrs			
HEMATOLOGY		GENERAL CHEMISTRY		HEPATITIS		OTHER TESTS NOT LISTED	
CBC <input type="checkbox"/> CBC (Hgb, Hct, RBC Indices, platelets, WBC) CBCD <input type="checkbox"/> CBC & Differential HB <input type="checkbox"/> hemoglobin HCT <input type="checkbox"/> hematocrit PLT <input type="checkbox"/> platelet count WBC <input type="checkbox"/> WBC RETIC <input type="checkbox"/> reticulocyte count PC <input type="checkbox"/> blood film to pathology		GLUF <input type="checkbox"/> glucose fasting (8h) + GLUP <input type="checkbox"/> glucose 2 h PC + GTT2 <input type="checkbox"/> 2h GTT (fast 10h)+ GLUCR <input type="checkbox"/> glucose, random NA <input type="checkbox"/> sodium K <input type="checkbox"/> potassium CL <input type="checkbox"/> chloride CO2 <input type="checkbox"/> CO2		HAVM <input type="checkbox"/> Hep A Virus Ab IgM HAVG <input type="checkbox"/> Hep A Virus Ab IgG HSAG <input type="checkbox"/> Hep B Surface Ag HSAB <input type="checkbox"/> Hep B Surface Ab HCVAB <input type="checkbox"/> Hep C Virus Ab (give clinical details)		Vit D TOXICOLOGY Reason for request _____ Current meds _____ Drugs given in Emerg _____ OR To mother during delivery (newborn) _____	
MAL <input type="checkbox"/> malaria film PT <input type="checkbox"/> PT (INR) PTT <input type="checkbox"/> PTT FIB <input type="checkbox"/> fibrinogen QDDIM <input type="checkbox"/> quantitative D-dimer THAL <input type="checkbox"/> hemoglobinopathy SHBS <input type="checkbox"/> Hgb S screen		CRE <input type="checkbox"/> creatinine Pt Wt _____ in kg CA <input checked="" type="checkbox"/> calcium LD <input type="checkbox"/> LD PO4 <input type="checkbox"/> phosphate MG <input type="checkbox"/> magnesium TP <input type="checkbox"/> total protien ALB <input type="checkbox"/> albumin ALP <input type="checkbox"/> alk phos ALT <input type="checkbox"/> ALT UA <input type="checkbox"/> urate (uric acid) TBIL <input type="checkbox"/> bilirubin, total CBIL <input type="checkbox"/> bilirubin, conjugated NBIL <input type="checkbox"/> bilirubin, neonatal		DIABETES MONITORING HBA1C <input type="checkbox"/> hemoglobin A1c UALBR <input type="checkbox"/> microalbumin: creatinine IMMUNOLOGY /SEROLOGY ANA <input type="checkbox"/> antinuclear Ab ATTG <input type="checkbox"/> Anti-transglutaminase IgA RA <input type="checkbox"/> RA factor ASOT <input type="checkbox"/> ASO titre SYPH <input type="checkbox"/> Syphilis EIA RUBG <input type="checkbox"/> rubella IgG MONOS <input type="checkbox"/> mono test EBM <input type="checkbox"/> EB virus (IgM) TPO <input type="checkbox"/> thyroid antibodies		SCREENING TESTS Urine UAMP <input type="checkbox"/> amphetamine group UBARB <input type="checkbox"/> barbiturates UBENZ <input type="checkbox"/> benzodiazepines UCAN <input type="checkbox"/> cannabis metabolites UCOC <input type="checkbox"/> cocaine metabolite UMETD <input type="checkbox"/> methadone UOP <input type="checkbox"/> opiates (NOT oxycodone) UOXY <input type="checkbox"/> oxycodone UTCA <input type="checkbox"/> tricyclic antidepressants serum BARB <input type="checkbox"/> barbiturates BENZ <input type="checkbox"/> benzodiazepines TCA <input type="checkbox"/> tricyclic antidepressants	
URINE RANDOM		URINE, 24 h / Timed		TRANSFUSION MEDICINE		ENDOCRINE	
UMA <input type="checkbox"/> urinalysis UTPCR <input type="checkbox"/> protein:creatinine PREG <input type="checkbox"/> pregnancy test UALBR <input type="checkbox"/> microalbumin:creatinine BJ <input type="checkbox"/> urine protein electrophoresis		Special Collection Instructions <input type="checkbox"/> UNA <input type="checkbox"/> UK <input type="checkbox"/> UCL UTP <input type="checkbox"/> protein UCRE <input type="checkbox"/> creatinine CRCL <input type="checkbox"/> creatinine clearance Pt ht _____ cm, wt _____ kg UMET <input type="checkbox"/> metanephries UCOR <input type="checkbox"/> cortisol UALB <input type="checkbox"/> microalbumin		ABORH <input type="checkbox"/> ABO and Rh Indication: _____		CORA <input type="checkbox"/> cortisol AM 0800-1000 CORP <input type="checkbox"/> cortisol PM 1500-1700 DHEAS <input type="checkbox"/> DHEAS E2 <input type="checkbox"/> estradiol FSH <input type="checkbox"/> FSH LH <input type="checkbox"/> LH PROG <input type="checkbox"/> progesterone PRL <input type="checkbox"/> prolactin PTH <input type="checkbox"/> PTH* calcium _____ HCG <input type="checkbox"/> quant. HCG TSHO <input type="checkbox"/> TSH (only) TSH <input type="checkbox"/> TSH (progressive) TESTA <input type="checkbox"/> testosterone AM (0800-1000 h)† OR TESTP <input type="checkbox"/> testosterone PM (1500-1700 h)†	
URINE, 24 h / Timed		PRENATAL		THERAPEUTIC DRUG MONITORING			
C3 <input type="checkbox"/> complement C3 C4 <input type="checkbox"/> complement C4 IGQ <input type="checkbox"/> IgA, IgG, IgM (Quant) IGE <input type="checkbox"/> IgE SPE <input type="checkbox"/> serum protein electrophoresis LDL <input type="checkbox"/> LDL cholesterol (12h fasting)# HDL <input type="checkbox"/> HDL cholesterol (12h fasting)# TRIG <input type="checkbox"/> triglycerides (12h fasting)# CHOL <input type="checkbox"/> cholesterol		For initial blood group and serology testing special prenatal req required HB <input type="checkbox"/> hemoglobin UMA <input type="checkbox"/> urinalysis GDS <input type="checkbox"/> GDS Gestational Diabetes Screen GTTPR <input type="checkbox"/> 2h GTT Pregnancy Fasting - 10 h		Complete for ALL drugs being monitored Drugs to be monitored _____ Dose regimen / route _____ Time last dose STARTED _____ COMPLETED _____ Time of next dose _____ How long on this dose regimen _____		CARB <input type="checkbox"/> carbamazepine CYCLO <input type="checkbox"/> cyclosporine/PREDOSE CYCL2 <input type="checkbox"/> cyclosporine 2h POST DIG <input type="checkbox"/> digoxin LI <input type="checkbox"/> lithium PHB <input type="checkbox"/> phenobarbital PTN <input type="checkbox"/> phenytoin SIRO <input type="checkbox"/> sirolimus TAC <input type="checkbox"/> tacrolimus THEO <input type="checkbox"/> theophylline VA <input type="checkbox"/> valproate	
FLUIDS		REFERRED OUT TESTS		ANTIBIOTICS			
Fluid Type _____ SFGLU <input type="checkbox"/> CSF glucose SFTP <input type="checkbox"/> CSF protein SFCT <input type="checkbox"/> CSF cell count FLGLU <input type="checkbox"/> glucose FLPT <input type="checkbox"/> protein FLCT <input type="checkbox"/> cell count FLCRY <input type="checkbox"/> crystals		Additional req must accompany request HIVAB <input type="checkbox"/> HIV (Prov Lab) XPSA <input type="checkbox"/> PSA (Cross Cancer In) MOM <input type="checkbox"/> maternal hCG/AFP/E3		(select 1 box) PRE (trough) T _____ POST (0.5 - 1.0 h after dose end) P _____ Extended Interval Dose (7mg/kg) INTERVAL (8h after dose start) 8 Other I			
MISCELLANEOUS				GENT. gentamicin			
OB <input type="checkbox"/> occult blood physician and patient to discuss medications before testing PSEA <input type="checkbox"/> post vasectomy HIV <input type="checkbox"/> HIV (third party) PSA <input type="checkbox"/> PSA (third party) ECG <input type="checkbox"/> electrocardiogram to be read by DynaLIFE Panel Other _____				TOBR. tobramycin			
				VANC. vancomycin			
				AMIK. amikacin			