

**LONDON HEALTH SCIENCES CENTRE
GENERAL LABORATORY REQUISITION**

- Routine **STAT** (Medical Emergency) A.S.A.P.
 Pre-Op Pre-Dialysis Post-Dialysis

Clinical Data: _____

Ordering Physician: _____
(INCLUDE FIRST AND LAST NAME)

Collected By: _____

Date (YYYY/MM/DD) & Time Collected: _____

Patient Location: _____

- LEGEND:**
- | | |
|------------------------------------|---------------------------|
| B = Blue top tube (Sodium Citrate) | P = Pink top tube |
| GD = Gold top tube | G = Green top tube |
| R = Red clotted tube | (Lithium Heparin and Gel) |
| L = Lavender top tube (EDTA) | Gy = Grey top tube |
| | DKB = Dark Blue tube |

SAMPLE TYPE:

- Blood Other (specify): _____

HEMATOLOGY

- | | | |
|---|---|---|
| <input type="checkbox"/> CBC (L) | <input type="checkbox"/> Hemoglobinopathy Screen (L&GD) | <input type="checkbox"/> Malaria Film (L) |
| <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> Hereditary Spherocytosis Screen (L) | <input type="checkbox"/> Reticulocyte Count (L) |
| Biopsy for Pathology <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Infectious Mono Screen (L) | <input type="checkbox"/> Semen Analysis |
| <input type="checkbox"/> Fluid Cell Count & Differential | <input type="checkbox"/> Iron Deficiency Screen (<i>ferritin</i>) (G) | - Post Vasectomy/Reversal only |
| <input type="checkbox"/> Fluid Crystals | <input type="checkbox"/> Iron Overload Screen (G) | <input type="checkbox"/> Sickle Cell Screen (L) |
| <input type="checkbox"/> Folate (<i>red cell</i>) (L) | (<i>iron, ferritin, UIBC</i>) | <input type="checkbox"/> Vitamin B12 (GD) |

COAGULATION

- | | | |
|---|---|---|
| <input type="checkbox"/> INR (B) (Circle Therapy) | <input type="checkbox"/> D-Dimer for DVT/PE (B) | <input type="checkbox"/> Heparin (Anti-Xa) Assay (B) |
| <input type="checkbox"/> PTT (B) (Circle Therapy) | <input type="checkbox"/> DIC Screen (L&B) | Specify Heparin: _____ |
| Heparin S/C Heparin IV Warfarin | <input type="checkbox"/> Factor Assays (B) | <input type="checkbox"/> Hypercoagulation Screen (5B, 2L) |
| Other: _____ | Specify: _____ | (AT3, APA, PCF, PSF, APCR) |

GENERAL CHEMISTRY

- | | | |
|--|--|---|
| <input type="checkbox"/> Electrolytes (G) (Na, K, Cl, CO ₂) | <input type="checkbox"/> Bilirubin - Total (G) | Lipid Profile (G) <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Glucose (G) | <input type="checkbox"/> Bilirubin - Direct (G) | <input type="checkbox"/> Triglyceride |
| <input type="checkbox"/> Random <input type="checkbox"/> Fasting <input type="checkbox"/> PC | <input type="checkbox"/> Calcium (G) | <input type="checkbox"/> HDLc / LDLc |
| <input type="checkbox"/> Creatinine (G) | <input type="checkbox"/> Creatine Kinase (<i>Total CK</i>) (G) | <input type="checkbox"/> Magnesium (G) |
| <input type="checkbox"/> Urea (G) | <input type="checkbox"/> Gamma Glutamyl Transferase (<i>GGT</i>) (G) | <input type="checkbox"/> Oligoclonal Banding (3mL CSF + GD) |
| <input type="checkbox"/> Alanine Transaminase (<i>ALT</i>) (G) | <input type="checkbox"/> Glycated Hemoglobin (L) | <input type="checkbox"/> Osmolality (G) |
| <input type="checkbox"/> Albumin (G) | <input type="checkbox"/> HCG - Quantitative (G) | <input type="checkbox"/> Phosphate (G) |
| <input type="checkbox"/> Alkaline Phosphatase (<i>ALP</i>) (G) | <input type="checkbox"/> Intact PTH (P) | <input type="checkbox"/> Pregnancy Test - Qualitative (GD) |
| <input type="checkbox"/> Amino Acids (G) | <input type="checkbox"/> Ionized Calcium (G) | <input type="checkbox"/> Protein - Total (G) |
| <input type="checkbox"/> Ammonia (L) *on ice | <input type="checkbox"/> Lactate (Gy) | <input type="checkbox"/> hs-Troponin T (G) |
| <input type="checkbox"/> Amylase - Total (G) | <input type="checkbox"/> Lactate Dehydrogenase (<i>LD</i>) (G) | <input type="checkbox"/> TSH (G) |
| <input type="checkbox"/> Aspartate Transaminase (<i>AST</i>) (G) | | <input type="checkbox"/> Uric Acid (G) |

BLOOD GASES

- | | | |
|--|---|--|
| <input type="checkbox"/> Arterial <input type="checkbox"/> Capillary <input type="checkbox"/> Venous | <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen | <input type="checkbox"/> Mechanical Ventilation: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Mask: _____ | Peep: _____ IMV: _____ CPAP: _____ |
| <input type="checkbox"/> Pt. Temp: _____ °C | <input type="checkbox"/> Nasal Prongs: _____ | <input type="checkbox"/> T Piece <input type="checkbox"/> T Collar <input type="checkbox"/> Other: _____ |

HEPATITIS AND DONOR HIV (SEND SEPARATE TUBE)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acute - Hepatitis A, B (G) | <input type="checkbox"/> Blood/Body Fluid Expos. - Source Pt. (G) | <input type="checkbox"/> Hepatitis B Surface Antibody (HBsAb) (G) |
| <input type="checkbox"/> Chronic - Hepatitis B, C (G) | <input type="checkbox"/> Blood/Body Fluid Exposure - Exposed Individual (G) | <input type="checkbox"/> Hepatitis B Core Antibody (HBcAb) (G) |
| <input type="checkbox"/> Transplant Screen (G) (HEP, HIV, CMV) | <input type="checkbox"/> HIV (Transplant Only) (G) | <input type="checkbox"/> Hepatitis Be Antigen (HBeAg) (G) |
| <input type="checkbox"/> Donor <input type="checkbox"/> Recipient (<i>check ONE only</i>) | <input type="checkbox"/> Hepatitis B Surface Antigen (HBsAg) (G) | <input type="checkbox"/> Hepatitis A Antibody (HAAb) (G) |
| <input type="checkbox"/> Immune Status/Previous Exposure (G) | | <input type="checkbox"/> Hepatitis C Antibody (HCAb) (G) |

URINE TESTS

- | | | |
|---|---|---|
| <input type="checkbox"/> Random Urine | <input type="checkbox"/> Citrate (24 hr. urine only)* | <input type="checkbox"/> Osmolality |
| <input type="checkbox"/> 24 hr Urine | <input type="checkbox"/> Creatinine | <input type="checkbox"/> Oxalate (24 hr. urine only)* |
| Collection Date | <input type="checkbox"/> Creatinine Clearance (G) + 24 hr urine | <input type="checkbox"/> PBG/ALA Porphyrin Precursors (dark) |
| Start: _____ Time: _____ h | <input type="checkbox"/> Cortisol (24 hr urine only) | <input type="checkbox"/> Porphyrins (dark) (random or 24 hr. urine*) |
| Finish: _____ Time: _____ h | <input type="checkbox"/> Hydroxyproline* | <input type="checkbox"/> Protein |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Metanephrines (fractionated)* (24 hr urine only) | <input type="checkbox"/> Protein Electrophoresis |
| <input type="checkbox"/> Aldosterone (24 hr urine only) | <input type="checkbox"/> Microalbumin | <input type="checkbox"/> VMA / HVA / HIAA by HPLC* (24 hr urine only) |
| <input type="checkbox"/> Calcium* | <input type="checkbox"/> Monoclonal Light Chains | *PRESERVATIVE REQUIRED
OBTAIN CONTAINER FROM LAB |

PLEASE WRITE IN ADDITIONAL TESTS BELOW

DRUG MONITORING - THERAPEUTIC

<input type="checkbox"/> Pre-dose Collection Time: _____ <input type="checkbox"/> Post-dose Collection Time: _____ Infusion Time (with flush): _____ to _____ <input type="checkbox"/> Random <input type="checkbox"/> Carbamazepine (GD) <input type="checkbox"/> Cyclosporin <input type="checkbox"/> 2 hr post dose (L) <input type="checkbox"/> Trough (L)	<input type="checkbox"/> Digoxin (G) <input type="checkbox"/> Gentamicin (G) <input type="checkbox"/> Lithium (GD) <input type="checkbox"/> Methotrexate (G) <input type="checkbox"/> Mycophenolic Acid (L) <input type="checkbox"/> Phenobarbital (G) <input type="checkbox"/> Phenytoin (G) <input type="checkbox"/> Free Phenytoin (G) <input type="checkbox"/> Primidone (G) <input type="checkbox"/> Sirolimus (L) <input type="checkbox"/> Tacrolimus (<i>FK506</i>) (L)	<input type="checkbox"/> Theophylline (G) <input type="checkbox"/> Tobramycin (G) <input type="checkbox"/> Valproic Acid (G) <input type="checkbox"/> Free Valproic Acid (GD) <input type="checkbox"/> Vancomycin (G)
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TOXICOLOGY

Current Medications: _____ _____ _____	Urine Drug Screen <input type="checkbox"/> Amphetamines/Ecstasy <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Cannabinoids <input type="checkbox"/> Cocaine Metabolites <input type="checkbox"/> Opiates (except Oxycodone) <input type="checkbox"/> Other (<i>Specify</i>): _____ _____	Serum Drug Screen <input type="checkbox"/> Acetaminophen (G) <input type="checkbox"/> Ethanol (G) <input type="checkbox"/> Glycol (GD) <input type="checkbox"/> Salicylates (G) <input type="checkbox"/> Tricyclics (G) <input type="checkbox"/> Volatiles (methanol, etc) (G)
Drug or poisons suspected: _____ _____ _____		

TRACE ELEMENTS

<input type="checkbox"/> Aluminum (DKB) <input type="checkbox"/> Copper (DKB)	<input type="checkbox"/> Lead (DKB) <input type="checkbox"/> Mercury (DKB)	<input type="checkbox"/> Zinc (DKB) <input type="checkbox"/> Other (<i>Specify</i>): _____
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HORMONES

<input type="checkbox"/> ACTH (L) *on ice <input type="checkbox"/> Aldosterone - standing (L) <input type="checkbox"/> Aldosterone - supine (L) <input type="checkbox"/> B2 Microglobulin (GD) <input type="checkbox"/> C-Peptide (GD) <input type="checkbox"/> Calcitonin (R) <input type="checkbox"/> Catecholamines (L) <input type="checkbox"/> Cortisol (GD) <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> DHEA Sulphate (GD) <input type="checkbox"/> Estradiol (GD) <input type="checkbox"/> FSH / LH (GD) <input type="checkbox"/> Gastrin (R) <input type="checkbox"/> Growth Hormone (GD) <input type="checkbox"/> 17-Hydroxyprogesterone (R) <input type="checkbox"/> Insulin (GD) <input type="checkbox"/> Progesterone (GD)	<input type="checkbox"/> Prolactin (GD) <input type="checkbox"/> Renin (L) <input type="checkbox"/> Testosterone - Total (GD) <input type="checkbox"/> Testosterone Index (FAI) (GD) <input type="checkbox"/> Thyroglobulin (R)
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IMMUNOLOGY

<input type="checkbox"/> Allergic Alveolitis (GD) <input type="checkbox"/> Alpha 1 Antitrypsin (GD) <input type="checkbox"/> Anti-Acetylcholine Receptor (GD) <input type="checkbox"/> Anti-Cyclic Citrullinated Peptide (R) <input type="checkbox"/> Anti-DNA (GD) <input type="checkbox"/> Anti-ENA Screen and ID (GD) <input type="checkbox"/> Anti-GM1 (GD) <input type="checkbox"/> Anti-Histone (GD) <input type="checkbox"/> Anti-Nuclear Antibody (GD) <input type="checkbox"/> Ceruloplasmin (GD)	<input type="checkbox"/> Complement C2 (R) *on ice <input type="checkbox"/> Complement C3/C4 (GD) <input type="checkbox"/> Complement CH50 (Total) (GD) *on ice <input type="checkbox"/> Cryofibrinogen (4B, 2R) *keep at 37°C <input type="checkbox"/> Cryoglobulin (2R) *keep at 37°C <input type="checkbox"/> Haptoglobin (GD) <input type="checkbox"/> Immune Complexes (<i>CIQ Binding Assay</i>) (R) *on ice <input type="checkbox"/> Immunoglobulins - IgA, IgG, IgM (GD)	<input type="checkbox"/> Neuropathy Associated Antibodies Please specify antibody: _____ <input type="checkbox"/> Phadiatop (<i>Atopy Screen</i>) (GD) <input type="checkbox"/> Prealbumin (GD) <input type="checkbox"/> Protein Electrophoresis (GD) <input type="checkbox"/> Rheumatoid Factor (GD) <input type="checkbox"/> Specific IgE (GD) *attach RAST requisition <input type="checkbox"/> Total IgE (R) <input type="checkbox"/> Transferrin (GD) <input type="checkbox"/> Trypsin (GD)
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FLOW CYTOMETRY

Check Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Other <input type="checkbox"/> Biopsy Type: _____ <input type="checkbox"/> Other Sample Type: _____	<input type="checkbox"/> CD4/CD8 <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma	<input type="checkbox"/> CD34 (Check one) <input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Apheresis Pack
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TUMOR MARKERS

<input type="checkbox"/> Alpha Fetoprotein (R) *non-pregnant (special reqn. for pregnant patients) <input type="checkbox"/> CA 19 (GD)	<input type="checkbox"/> CA 125 (GD) <input type="checkbox"/> CEA (GD)	<input type="checkbox"/> PSA (R)
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