



# REFERRED OUT TESTING REQUISITION

Ph: (867) 393-8739 fax: (867) 393-8772

Laboratory Use Only

Number of samples sent

LAST NAME _____		FIRST NAME _____	
DATE OF BIRTH (dd/mm/yy) _____ / _____ / _____		HEALTH CARE # _____ (Prov) _____ M <input type="checkbox"/> F <input type="checkbox"/>	
SUBMITTING DOCTOR _____	CLINIC/HEALTH CENTRE _____	DIAGNOSIS _____	
COPY OF REPORT TO: _____			
Send copy to: Whitehorse General Hospital Laboratory		Patient fasting: <input type="checkbox"/> Y <input type="checkbox"/> N	

## Specimen Collection

Date: \_\_\_\_\_

Time: \_\_\_\_\_

By: \_\_\_\_\_

### SPH:

- |  |  |
|--|--|
| <input type="checkbox"/> Alpha 1 Antitrypsin (A1A)                                 | <input type="checkbox"/> LH  |
| <input type="checkbox"/> Anti Thrombin III   | <input type="checkbox"/> Progesterone  |
| <input type="checkbox"/> Anti Thyroperoxidase                                      | <input type="checkbox"/> Prolactin   |
| <input type="checkbox"/> Aldosterone (booked collection) random / upright / supine | <input type="checkbox"/> Protein C   |
| <input type="checkbox"/> APO A Lipoprotein   | <input type="checkbox"/> Protein Electrophoresis                             |
| <input type="checkbox"/> APO B Lipoprotein   | <input type="checkbox"/> Protein S   |
| <input type="checkbox"/> B12   | <input type="checkbox"/> PTH, intact   |
| <input type="checkbox"/> C3  | <input type="checkbox"/> Renin (booked collection) random / upright / supine |
| <input type="checkbox"/> C4  | <input type="checkbox"/> Ristocetin co-factor                                |
| <input type="checkbox"/> Cortisol a.m. (0700 – 1000hr)                             | <input type="checkbox"/> Tacrolimus _____ time of last dose                  |
| <input type="checkbox"/> Cortisol p.m. (1400 – 1600hr)                             | _____ time of last dose  |
| <input type="checkbox"/> Cortisol, random  | <input type="checkbox"/> Testosterone _____ date of last dose                |
| <input type="checkbox"/> Cyclosporin _____ date of last dose                       | (prior to 10:00 a.m.)  |
| <input type="checkbox"/> DHEA-S  | <input type="checkbox"/> Thyroglobulin                                       |
| <input type="checkbox"/> DRVVT (Lupus Anticoagulant)                               | <input type="checkbox"/> Transferrin Panel (iron, transferrin + saturation)  |
| <input type="checkbox"/> Estradiol   | <input type="checkbox"/> TSH Receptor Antibody                               |
| <input type="checkbox"/> FSH   | <input type="checkbox"/> Valproic Acid _____ date of last dose               |
| <input type="checkbox"/> FT3   | _____ date of last dose  |
| <input type="checkbox"/> FT4   | <input type="checkbox"/> Vitamin D, 25-Hydroxy (Nutritional)                 |
| <input type="checkbox"/> IgE   | <input type="checkbox"/> Vitamin D 1, 25-Dihydroxy (Metabolic)               |
| <input type="checkbox"/> Immunoglobulins   |  |
| <input type="checkbox"/> Insulin   |  |

### VGH:

- ANA
- Anti cardiolipin IgG & IgM
- Anti CCP
- Anti DNA
- Anti smooth muscle Antibody
- Anti tissue transglutaminase (TTG)
- ENA
- Factor V Leiden
- HLA B27 (need patient history)
- Homocysteine
- Sirolimus \_\_\_\_\_ date of last dose \_\_\_\_\_ time of last dose

### BCCH:

- Amino Acids (plasma)  Lead, blood
- Mercury, blood

### OTHER TESTING:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### Urine Testing:

- Catecholamines & Metanephrines (medication restrictions) \_\_\_\_\_ start date \_\_\_\_\_ end date
  - Cortisol \_\_\_\_\_ start time \_\_\_\_\_ end time
  - 5-Hydroxyindole acetic acid (5-HIAA) (restrictions) \_\_\_\_\_ total volume in mls \_\_\_\_\_ random sample
  - Mercury (special collection container)
- Preservative added  Y  N  
Name of preservative \_\_\_\_\_ Volume \_\_\_\_\_ mls