

Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	DOB (DD/MMM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK
PATIENT SURNAME	PATIENT FIRST AND MIDDLE NAME	
ADDRESS	CITY	POSTAL CODE

DATE RECEIVED

PHSA LABORATORIES USE ONLY

OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#) Name and address of report delivery	ADDITIONAL COPIES TO: (Address / MSC#) 1. 2. 3.
<input type="checkbox"/> I do not require a copy of the report	
CLINIC OR HOSPITAL Name and address of report delivery	
PHSA CLIENT NO.	

SAMPLE REF. NO.

DATE COLLECTED
(DD/MMM/YYYY)

TIME COLLECTED
(HH:MM)

Section 3 - Test(s) Requested

PATIENT STATUS <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> ER patient <input type="checkbox"/> History of contact with infection <input type="checkbox"/> Travel history _____	SIGNS / SYMPTOMS Date of Onset: _____ (DD/MMM/YYYY) <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Cough <input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Lower Respiratory Infection <input type="checkbox"/> Other, specify: _____	
RESPIRATORY VIRUSES <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Nasal swab <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Nasal wash <input type="checkbox"/> Other, specify: _____ Tested by Influenza A <input type="radio"/> Positive <input type="radio"/> Negative POC for: Influenza B <input type="radio"/> Positive <input type="radio"/> Negative RSV <input type="radio"/> Positive <input type="radio"/> Negative	HERPES VIRUSES <input type="checkbox"/> Genital lesion for HSV <input type="checkbox"/> Non-genital lesion for HSV <input type="checkbox"/> Skin swab for Varicella-Zoster <input type="checkbox"/> Other, specify: _____ Urine for: <input type="checkbox"/> Cytomegalovirus	GASTROINTESTINAL VIRUSES Feces* for: <input type="checkbox"/> Rotavirus/Adenovirus <input type="checkbox"/> Norovirus <input type="checkbox"/> Other, specify: _____ <small>*Guideline for Ordering Stool Specimens www.bccdc.ca/gpac/guideline_diarrhea.html</small>
HEPATITIS VIRUSES Blood for: <input type="checkbox"/> Qualitative HCV RNA (diagnosis) <input type="checkbox"/> Quantitative HCV RNA (treatment only) <input type="checkbox"/> Baseline <input type="checkbox"/> Week, specify: _____ <input type="checkbox"/> HCV Genotyping	ENCEPHALITIS / MENINGITIS Cerebrospinal Fluid for: <input type="checkbox"/> Encephalitis (e.g. HSV-1, West Nile Virus) <input type="checkbox"/> Meningitis (HSV-2, Enterovirus) <input type="checkbox"/> Other, specify: _____	MEASLES / RUBELLA VIRUSES <input type="checkbox"/> Measles <input type="checkbox"/> Rubella <input type="checkbox"/> Urine <input type="checkbox"/> Nasal / Nasopharyngeal swab <input type="checkbox"/> Other, specify: _____
For other available tests and additional information, consult the BCCDC Public Health Laboratory's <i>Guide to Programs and Services</i> at http://www.bccdc.ca/health-professionals/professional-resources/laboratory-services		MUMPS VIRUSES <input type="checkbox"/> Buccal swab <input type="checkbox"/> Urine
		BIOPSY / AUTOPSY / OTHER TESTS <input type="checkbox"/> Specify: _____

DATE INOC.		PHSA LABORATORIES USE ONLY			
DATE	DAY	A549	MK		

PHSA Laboratories

BCCDC Public Health Laboratory

BC Centre for Disease Control, 655 West 12th Avenue, Vancouver, BC V5Z 4R4 <http://www.bccdc.ca/health-professionals/professional-resources/laboratory-services>

DATE INOC.		PHSA LABORATORIES USE ONLY			
DATE	DAY	A549	MK	MRC-5	
	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
	9				
	10				
	11				
	12				
	13				
	14				
	15				
	16				
	17				
	18				
	19				
	20				
	21				

