

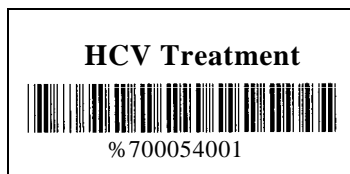


BC Centre for Disease Control
 AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

BCCDC Laboratory Services
 655 West 12th Ave
 Vancouver BC V5Z 4R4

Pegylated Interferon and Ribavirin Hepatitis C Treatment Monitoring

Requisition



Please supply the following information

Patient Last Name:	First Name:	Middle Name:	Gender: M F	Date of Birth:(dd/mmm/yyyy) / /
Address:			City:	Province:
Personal Health No.	Collection Date	Time		

Physician Name:	BC Billing # (if applicable):	
Address:	City:	Province:
Phone Number:	Fax Number:	Postal Code:

Information for the blood collection site:

Please ship with a cooling pack to BC Centre for Disease Control
One dedicated 7ml EDTA or 2-5ml EDTA tubes for nucleic acid testing.
To order more forms, please send request by fax to 604-660-1360

<p>Please check off appropriate test(s)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Qualitative PCR testing for diagnosis <input type="checkbox"/> HCV genotyping <input type="checkbox"/> Pretreatment quantitative PCR only for genotype 1,4,5,6 <input type="checkbox"/> Week 12 viral load quantitative PCR testing only for genotype 1,4,5,6 <input type="checkbox"/> Follow up: week 24___ 48___ 72___ Other_____
