

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

VIRUSES	BACTERIA	PARASITES
<input type="checkbox"/> Arbovirus Panel Eastern Equine Encephalitis, Western Equine Encephalitis, Powassan, St. Louis Encephalitis <input type="checkbox"/> Dengue Virus Antibody <input type="checkbox"/> Hanta Virus Antibody <input type="checkbox"/> West Nile Virus Antibody <input type="checkbox"/> Other, specify: _____ Travel / Clinical History Required for Above Tests: _____ _____ Signs / Symptoms <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Insect bite: <input type="checkbox"/> Skin rash: Type/Location _____ <input type="checkbox"/> Neurological <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Anti-Streptolysin O (ASO) / Anti-DNase B <input type="checkbox"/> <i>Bartonella henselae</i> Antibody <input type="checkbox"/> <i>Borrelia burgdorferi</i> (Lyme disease) Antibody <input type="checkbox"/> <i>Borrelia hermsii</i> Antibody <input type="checkbox"/> <i>Brucella abortus</i> Antibody <input type="checkbox"/> <i>Coxiella burnetii</i> (Q-fever) Antibody <input type="checkbox"/> <i>Francisella tularensis</i> Antibody <input type="checkbox"/> <i>Helicobacter pylori</i> Antigen (Feces) <input type="checkbox"/> <i>Legionella</i> species Urine Antigen <input type="checkbox"/> <i>Leptospira</i> Antibody <input type="checkbox"/> <i>Rickettsia rickettsii</i> Antibody (Rocky Mountain Spotted Fever) <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> <i>Echinococcus</i> Antibody <input type="checkbox"/> <i>Entamoeba histolytica</i> (Amoebiasis) Antibody <input type="checkbox"/> <i>Schistosoma</i> Antibody <input type="checkbox"/> <i>Strongyloides</i> Antibody Travel History Required for Above Tests: <input type="checkbox"/> Travel within past 12 months, specify: _____ _____ <input type="checkbox"/> <i>Leishmania</i> Antibody <input type="checkbox"/> <i>Toxoplasma gondii</i> Antibody <input type="checkbox"/> <i>Trichinella</i> Antibody <input type="checkbox"/> <i>Trypanosoma cruzi</i> (American trypanosomiasis) Antibody <input type="checkbox"/> Other, specify: _____
SYPHILIS	FUNGI	* CONSULTATION REQUIRED Please telephone Program Head (Medical Microbiologist) at (604) 707-2622 For other available tests and additional information, consult the Public Health Microbiology & Reference Laboratory's <i>Guide to Programs and Services</i> at www.phsa.ca/bccdcpublichealthlab
<input type="checkbox"/> VDRL (CSF sample only) Submit 1 mL CSF in sterile leak-proof tube <input type="checkbox"/> <i>Treponema pallidum</i> Nucleic Acid Testing* Submit exudate, tissue or body fluid <input type="checkbox"/> Darkfield (DF) Microscopy Source of sample: _____ <input type="checkbox"/> Direct Fluorescent Assay (DFA) Microscopy Source of sample: _____ Signs / Symptoms <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Rash <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> <i>Blastomyces dermatidis</i> Antibody <input type="checkbox"/> <i>Coccidioides</i> species Antibody <input type="checkbox"/> <i>Cryptococcus neoformans</i> Antigen <input type="checkbox"/> <i>Histoplasma</i> Antibody <input type="checkbox"/> Other, specify: _____ Travel History Required for Above Tests: <input type="checkbox"/> Travel within past 12 months, specify: _____ _____	

PHSA Laboratories

Public Health Microbiology & Reference Laboratory

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