Health PEI

Hepatitis C Virus Treatment Program – Patient Referral

Date of Referral: _____ Referring Individual: _____
(Does not need to be a healthcare practitioner)

Referring Individual Contact Information: _____

Patient Information		
Last name:	**First name:**	
Gender:	**DOB:**	**MRN:**
Primary contact #:	**Alternate contact #:**	
Address:		
Relevant past medical history:		
Medications:		
Allergies:		
Other health care providers involved in patient's care:		
Recent blood work done or sent to lab: Y ( ) N ( ) Unsure ( ) **Lab blood tests (Green form):** **CBC, A1C, INR, Electrolytes, Creatinine, Albumin, Bilirubin (total & direct),** **ALT, AST (add at bottom under Additional Requests), ALP, GGT;** **B-HcG if chance of pregnancy; AFP and ferritin only if known or suspected cirrhosis** **Micro serology (Blue form):** **HCV Antibody, HCV Viral Load (2 large red-top tubes), HCV Genotype,** **HBV Antibody, HBV Total core Antibody, HBV Antigen, HAV IgG, HIV Ag/Ab, Syphilis**		
Thought to be HCV+ since:	**Previously referred to or seen by HCV program:** **Y ( ) N ( ) Unsure ( )**	

Please send the completed referral form to:
Provincial HCV Elimination Program
Email: peihepc@ihis.org or Fax: 902-569-7633
Questions? Please call us at 902-569-7642

LABORATORY BLOOD TEST REQUEST FORM (2021)

Provincial Clinical Laboratory

Address for Non PEI Residents Required

Name: Place Label Here

Street: HCV workup

City: Prov./State:

Postal Code/Zip: Patient Phone #:

Specimen Collected	Fasting	Payment Responsibility
By:	Yes ☐	☐ WCB ☐ DVA ☐ DND ☐ RCMP
Date: YYYY/MMM/DD	No ☐	☐ Self Pay Non-Canadian ☐ Self Pay Canadian
Time: HH:MM		Provincial Medicare # exp. date:

Relevant Diagnosis and Therapy

DOB: YYYY-MMM-DD | Sex | Medical Record Number (MRN)

Ordering Physician/NP (FIRST & LAST NAME) | Location

Copies (Full name required. Fax # required for Out of Province Providers)
Hepatitis C Program 902-569-7633

BLOOD REQ

Chemistry - Collect 1 Yellow Tube (SST)

Glucose testing requires a gray tube, special tubes as indicated.

☐ Glucose - Fasting	✓ Alk Phos - ALP	☐ CRP
☐ Glucose - Random	✓ ALT	☐ Ammonia (*Green on Ice*)
✓ Electrolytes ☐ CO_2	✓ GGT	☐ Calcium - Ionized
✓ Creatinine - eGFR	☐ LD	☐ Osmolality
☐ Calcium - Total	☐ Lipase	☐ Lactate (*Green on Ice*)
☐ Total Protein	☐ CK	☐ Uric Acid - Urate
✓ Albumin	☐ Serum Pregnancy	☐ Phosphate
✓ Total Bilirubin	✓ Bilirubin - Direct	

Cardiac Function and Lipids

☐ HS-CRP - Cardiac	☐ BNP (*Purple Tube*)	☐ Troponin (*Green Tube*)

☐ Non- Fasting Lipid Profile (Cholesterol, LDL, HDL & Triglycerides)
☐ Fasting Lipid Profile (Cholesterol, LDL, HDL & Triglycerides)
☐ Fasting Triglycerides

Tolerance Tests - Glucose & Lactose (Appointment required)

☐ 50 g Gestational - Screen ☐ 75 g Diabetic - Confirmatory
☐ 75 g Gestational - Confirmatory ☐ Lactose Tolerance Test
☐ 75 g Post-partum - Screen (Gestational Diabetes Patients)

Nutritional Status

☐ Ferritin	☐ Iron Studies (Iron,Transferrin/TIBC & %Sat)	
☐ Prealbumin	☐ Vitamin B12	

Endocrine & Tumor Markers - Collect 1 Yellow SST Tube

Special tubes as indicated.

☐ Prolactin	☐ Progesterone	☐ CA-125
☐ DHEAS	☐ Estradiol	☐ CEA
☐ Cortisol _____ *hrs*	☐ FSH	☐ AFP
☐ PTH - intact (*red tube*)	☐ LH	☐ β-HcG (Quantitative)
☐ PSA	☐ CA 15-3	☐ Testosterone - Total
☐ TSH - **Diagnostic**	☐ TSH - **Monitor Tx**	

Blood Gases - Collect in a Heparinized Syringe, Send on Ice

Special tubes as indicated.

Specimen: ☐ Arterial ☐ Capillary ☐ Central/Mixed Venous ☐ Venous (*Green Tube on Ice*) ☐ Cord (*Send Cord on Ice*)

02 Device: **O2 Therapy:** **Body Temp:**

☐ Carboxyhemoglobin-CO ☐ Methemoglobin ☐ Lactate

BLOOD REQ

Hematology - Collect 1 Purple Tube (EDTA)

✓ CBC & Auto Diff	☐ Reticulocyte Count	
✓ A1C	☐ Kleihauer	

Coagulation - Collect 1 Blue Tube (Sodium Citrate)

Check if the patient is a Hemophiliac ☐

✓ PT/INR	☐ aPTT	☐ D-dimer	☐ Fibrinogen

Immunology - Collect 1 Red Tube for Each 3 Tests

☐ Tissue Transglutaminase	☐ IgG, IgA & IgM	☐ IgE
☐ Protein Electrophoresis	☐ ANA Screen	☐ dsDNA
☐ Vasculitis (MPO & PR3)	☐ Anti-GBM	☐ Haptoglobin
☐ Rheumatoid Factor	☐ ASOT	☐ Cardiolipin
☐ CCP (Citrulline Ab)	☐ AMA	☐ β2-Microglobulin
☐ Serum Free Light Chains	☐ Ceruloplasmin	☐ α-1-Antitrypsin
☐ Complement C3 & C4	☐ Hypersensitivity Pneumonitis Panel	

Therapeutic Drug Monitoring - 1 Red Tube (*special tubes indicated*)

Date & Time of last dose REQUIRED

☐ Carbamazepine (Tegretol)	MMM/DD, HH:MM
☐ Digoxin	MMM/DD, HH:MM
☐ Lithium	MMM/DD, HH:MM
☐ Phenobarbital	MMM/DD, HH:MM
☐ Phenytoin (Dilantin)	MMM/DD, HH:MM
☐ Primidone (Mysoline)	MMM/DD, HH:MM
☐ Valproic Acid (Epival)	MMM/DD, HH:MM
☐ Tacrolimus (*2 purple tubes*) ☐ New baseline ☐ Established	MMM/DD, HH:MM
☐ Cyclosporine (*purple tube*) ☐ Pre-dose ☐ Post- dose	MMM/DD, HH:MM
☐ Vancomycin ☐ Pre-dose ☐ Post-dose	MMM/DD, HH:MM
☐ Gentamicin (*refer to back page for regimen*)	MMM/DD, HH:MM specify regimen:
☐ Tobramycin (*refer to back page for regimen*)	MMM/DD, HH:MM specify regimen:

Date & Time IV Infusion Completed:

Serum Toxicology - 1 Red Tube

☐ Ethanol	☐ Acetaminophen	☐ Salicylate
☐ Tricyclics - Screen		

BLOOD REQ

Additional Requests

(Please Contact Lab for Special Instructions and Availability)

* AST

Note: Please check B-HcG if possibility of pregnancy

101038.0007

MICROBIOLOGY SEROLOGY REQUEST FORM (2021)

Provincial Clinical Laboratory
Website: https://src.healthpei.ca /microbiology

HCV work up

Specimen Collected	Payment Responsibility
By: Date: YYYY/MMM/DD Time: HH:MM	☐ WCB ☐ DVA ☐ DND ☐ RCMP ☐ Self Pay Canadian ☐ Self Pay Non-Canadian Provincial Medicare # exp. date:

Clinical Diagnosis	DOB MMM-DD-YYYY	Sex	Medical Record Number (MRN)

Ordering Physician/NP	Location	Copies (Full name required. Fax# required for out of province providers)
FIRST & LAST NAME		Hepatitis C Program 902-569-7633

INFECTIOUS DISEASE SEROLOGY (Collect MAX: 3-4 Red /SST Tubes)

Note: HCV Viral Load requires 2 dedicated full large Red / SST Tubes

VIRAL BLOOD SEROLOGY

	Immunity	Infection	Management
Hepatitis B	✓HBV Antibody	✓HBV Total core Antibody ✓HBV Antigen	☐ HBV Viral Load ☐ HBeAg
Hepatitis C		✓HCV Antibody	✓HCV Viral Load ✓HCV Genotype
Hepatitis A	Not Required	☐ HAV IgM ✓HAV IgG	
HIV		✓HIV Ag/Ab	☐ HIV Viral Load (EDTA Tube)
CMV	☐ IgG	☐ IgM	☐ CMV Viral Load (EDTA Tube)
EBV	☐ EBV Screen & reflex testing		
HTLV I & II	☐ IgG (limited to renal and transplant patients)		

VIRAL EXANTHEMA

Immunity	Infection
☐ Measles IgG	☐ Measles IgM (PCR preferred)
☐ Mumps IgG	☐ Mumps IgM (See PCR)
☐ Rubella IgG	☐ Rubella IgM
☐ Varicella zoster IgG	☐ Varicella zoster IgM (PCR recommended)
☐ Parvovirus B19 IgG	☐ Parvovirus B19 IgM

BACTERIAL IMMUNOLOGY
(Requires Paediatrician or Allergist Approval)

☐ Tetanus Toxoid	☐ *Streptococcus pneumoniae*
☐ Diphtheria Toxoid	

FUNGAL BLOOD TESTING

☐ Beta-D-Glucan	☐ Galactomannan

PARASITE SEROLOGY

☐ Strongyloidiasis Serology	☐ Schistosomiasis Serology
☐ Toxoplasma IgG	☐ Toxoplasma IgM

Note: Mycobacterium blood testing (IGRA) is available by appointment only at QEH or PCH due to special handling.

SEROLOGY PANELS

- ☐ Needlestick Exposed = HBsAg, HBcAb, HCV and HIV
- ☐ Needlestick Follow Up (>=3 Mon)= HBsAg, HBsAb, HCV and HIV
- ☐ Needlestick Source = HBsAg, HCV and HIV **"Page Micro"**
- ☐ Prenatal Serology = HBsAg, HIV, Rubella IgG and Syphilis
- ☐ Arbovirus Serology = Zika*, Dengue & Chikungunya

***Information Required for Zika Testing:**
Pregnant: ☐ IVF Treatment: ☐
Travel Date(s): _____ Travel Location(s): _____
Symptoms: _____

BACTERIA / GENERAL SEROLOGY

- ✓Syphilis Screen
- ☐ Mycoplasma IgM Antibody (PCR available)
- ☐ Lyme Disease Serology
  Travel Date(s): _____ Travel Location(s): _____
  Tick Bite Duration: ☐ <36 hrs ☐ > 36 hrs ☐ unknown
  Clinical features suggestive of Lyme disease: _____

BLOOD CULTURES

☐ Suspected endocarditis

☐ Routine Culture Set	☐ Peripheral: Specify site _____
☐ Mycobacterium	☐ Central Line: Specify type & Lumen
☐ Fungal other than yeast	☐ Other: Specify _____
☐ Paediatric	

Special Requests (please see guide to services for full lists of tests)

MICRO SERO REQ

MICRO SERO REQ
MICRO SERO REQ
MICRO SERO REQ