BRITISH COLUMBIA | Ministry of Health

STANDARD OUT-PATIENT LABORATORY REQUISITION FOR MATERNITY CARE

Yellow highlighted fields must be completed to avoid delays in specimen collection and patient processing.

For tests indicated with a blue tick box ☐, consult provincial guidelines and protocols (www.BCGuidelines.ca)

Bill to ➠ ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ PATIENT ☐ OTHER: _____

PERSONAL HEALTH NUMBER (PHN)	ICBC/WorkSafeBC NUMBER	ORDERING PRACTITIONER: ADDRESS, MSP PRACTITIONER NUMBER
LAST NAME OF PATIENT	FIRST NAME OF PATIENT	LOCUM FOR: PRACTITIONER NAME/MSP PRACTITIONER NUMBER:
DOB YYYY MM DD	SEX ☐ M ☐ F	ORDER PRACTITIONER NAME/MSP PRACTITIONER NUMBER:
	Fasting? _____ h pc	
PRIMARY CONTACT NUMBER OF PATIENT	SECONDARY CONTACT NUMBER OF PATIENT	OTHER CONTACT NUMBER OF PATIENT
		If this is a STAT order please provide contact telephone number:
ADDRESS OF PATIENT	CITY/TOWN	PROVINCE
		Copy to Practitioner/MSP Practitioner Number/Address:

DIAGNOSIS	ESTIMATED DATE OF CONFINEMENT (EDC)	CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE	ALLERGIES

TESTS PER THE PERINATAL SERVICES BC OBSTETRIC GUIDELINE

SERUM INTEGRATED PRENATAL SCREEN (SIPS):

- Part 1 at 9 - 13^{+6} weeks
- Part 2 at 14 - 20^{+6} weeks

QUAD SCREEN 14 - 20^{+6} WEEKS

- **Maternal Serum AFP only (see guideline for ordering instructions)**

Use separate requisitions for each screening test

Complete Prenatal Genetic Screening Laboratory Requisition located at:
http://www.perinatalservicesbc.ca/Documents/Screening/Prenatal-HCP/LabReqFillable.pdf

0 – 14 WEEKS: RECOMMENDED TESTS

- ☐ Blood group and Antibody screen - Complete the BCY Prenatal Screening Request located on the CBS site at https://blood.ca/en/hospitals/bc-yukon-centre/test-request-forms
- ☐ Hematology profile (CBC)
- ☐ TSH (for those with risk factors for hypothyroidism)
- ☐ HIV Serology - complete the Serology Screening Requisition located at http://lmlabs.phsa.ca/health-professionals/test-requisitions (patient has legal right to choose not to have their name reported to public health = non-nominal reporting)
  - ☐ Non-nominal reporting
- ☐ Syphilis Serology
- ☐ Hepatitis B (HBsAg) ☐ Hepatitis C (anti-HCV) (for women with risk factors)
- ☐ Rubella antibody titre (if first pregancy)

Chlamydia/Gonorrhea testing by NAAT

☐ Vaginal swab ☐ Cervical swab ☐ Urine

Urine

☐ Midstream urine for C&S, list current antibiotics _____

24 – 28 WEEKS: RECOMMENDED TESTS

- ☐ Repeat Antibody screen in D negative (Rh negative) women or as indicated on previous CBS report. Use the BCY Prenatal Screening Request form located at on the CBS site at: https://blood.ca/en/hospitals/bc-yukon-centre/test-request-forms
- ☐ GTT - gestational diabetes screen (50g load, 1 h - post load)
- ☐ GTT - gestational diabetes confirmation (75 g load, 8-10 h fasting, water permitted, 2 h test)

35 – 37 WEEKS: RECOMMENDED TESTS

- ☐ Hematology profile (CBC)

Group B Strep Screen ☐ Vagino-anorectal swab ☐ Penicillin allergy

SIGNATURE OF REQUESTING PRACTITIONER	DATE SIGNED

OTHER TESTS AS REQUIRED

CHEMISTRY

- ☐ Sodium
- ☐ Potassium
- ☐ Albumin
- ☐ Alk Phos
- ☐ ALT
- ☐ Bilirubin
- ☐ GGT
- ☐ Ferritin
- ☐ Uric Acid
- ☐ Creatinine
- ☐ Urine Protein/Creatinine Ratio
- ☐ Fasting glucose

OR

- ☐ Hemoglobin A1C if risk factors for Type II diabetes
- ☐ Pregnancy test
  - ☐ Urine ☐ Serum

VAGINITIS

- ☐ Initial (smear for Bacterial Vaginosis and yeast only)
- ☐ Chronic/recurrent (smear, culture, trichomonas)
- ☐ Trichomonas Testing

THYROID FUNCTION

For physican referrals only. For other thyroid investigations, please order specific tests below and provide diagnosis.

- ☐ Monitor thyroid replacement therapy (TSH Only)
- ☐ Suspected Hypothyroidism (TSH first ± fT4)
- ☐ Suspected Hyperthyroidism (TSH first, ± fT4, ± fT3)

HEMATOLOGY

- ☐ Thalassemia/hemoglobinopathy investigation
- ☐ INR
- ☐ PTT
- ☐ Fibrinogen

URINE

- ☐ Midstream urine for C&S, list current antibiotics _____
- ☐ Macroscopic → microscopic if dipstick positive
- ☐ Macroscopic → urine culture if pyuria or nitrite present
- ☐ Macroscopic (dipstick) ☐ Microscopic
- ☐ Special case (if ordered together)

OTHER TESTS AND/OR PATIENT INSTRUCTIONS

IMMUNITY/PAST INFECTION

- ☐ Rubella antibody IgG
- ☐ Varicella serology (if no known Hx of disease or immunization)
- ☐ Parvovirus B19 IgG serology
- ☐ CMV IgG serology
- ☐ Toxoplasmosis IgG serology

ACUTE/NEW INFECTION ONLY

- ☐ Mumps serology (for post-exposure or with symptoms)
- ☐ Rubella IgM
- ☐ Parvovirus B19 IgM serology
- ☐ CMV IgM serology
- ☐ Toxoplasmosis IgM serology

DATE OF COLLECTION	TIME OF COLLECTION	PHLEBOTOMIST	TELEPHONE REQUISITION RECEIVED BY (EMPLOYEE/DATE/TIME)

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.

HLTH 1935 2018/03/23

PRINT RESET