

Section 1 - Patient Information

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|---|--------------------------------------|--|
| 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 |

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|-----------------------------------|
| DATE RECEIVED |
| PHSA LABORATORIES USE ONLY |
| OUTBREAK ID |

Section 2 - Healthcare Provider Information

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| 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. | |

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| SAMPLE REF. NO. |
| DATE COLLECTED (DD/MMM/YYYY) |
| TIME COLLECTED (HH:MM) |

Section 3 - Test(s) Requested

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| 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 |
| 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: _____ |
| For other available tests and additional information, consult the Public Health Microbiology & Reference Laboratory's Guide to Programs and Services at www.phsa.ca/bccdcpublichealthlab | MUMPS VIRUSES <input type="checkbox"/> Buccal swab <input type="checkbox"/> Urine |
| | GASTROINTESTINAL VIRUSES Feces* for: <input type="checkbox"/> Rotavirus/Adenovirus <input type="checkbox"/> Norovirus <input type="checkbox"/> Other, specify: _____ *Guideline for Ordering Stool Specimens www.bccguidelines.ca/gpac/guideline_diarrhea.html |
| | 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: _____ |
| | BIOPSY / AUTOPSY / OTHER TESTS <input type="checkbox"/> Specify: _____ |

| DATE INOC. | | | PHSA LABORATORIES USE ONLY | | | |
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PHSA Laboratories

Public Health Microbiology & Reference Laboratory

BC Centre for Disease Control, 655 West 12th Avenue, Vancouver, BC V5Z 4R4 www.phsa.ca/bccdcpublichealthlab

| DATE INOC. | | PHSA LABORATORIES USE ONLY | | | |
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