

VALLEY MEDICAL / OKANAGAN CLINICAL LABORATORIES
HOUSE CALL REQUEST FORM (rev 2016-05)

(FOR PHYSICIAN OR CARE FACILITY USE ONLY)

Note: This service is limited to those people who for MEDICAL REASONS are PHYSICALLY INCAPABLE of attending the laboratory, subject to the following availability:

Location	Home Collection*	Care Facility Collection	Fax requests to:
Vernon	Yes	Yes	250-549-1259
Kelowna	Yes	Yes	250-862-2843
Penticton	No	Yes	250-493-2714
Osoyoos	Yes	Yes	250-495-2585

To request house call service from VML or OCL, please:

1. Complete the appropriate section below and the requisition to the right.
2. Please FAX the completed form to the appropriate number above.

* For patients that do not qualify for our housecall service, alternatives for transportation may be available, depending on where the patient lives. Please refer to our website (valleymedicallaboratories.com) for details. Go to "For Patients", then "Patient Transportation Options".

New House Call Collection Request

1. To commence the week of (date): _____
2. Reason for home collection request
(Use "Diagnosis / Clinical Information" section of requisition)
3. Required tests (use requisition)
4. Frequency of testing: _____
5. Duration of order: _____

Change to Existing House Call Collection

Cancel

Change frequency to (specify): _____

Additional visit for the week of (date): _____

Additional tests required (use requisition): _____

VALLEY MEDICAL LABORATORIES
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www.valleymedicallaboratories.com

(2017-02)

No Appointment Necessary
PLEASE PRESENT YOUR MEDICAL CARD
**** Please see reverse for locations and test instructions.****



LAB DEMO LABEL

Highlighted fields (yellow shading) must be completed to avoid delays in specimen collection and processing.

For tests indicated with an asterisk * consult provincial guidelines and protocols, at www.BCGuidelines.ca.

BILL TO → MSP ICBC WorkSafeBC PATIENT OTHER: _____

PHN NUMBER _____ ICBC / WorkSafe BC _____

ORDERING PHYSICIAN: NAME, ADDRESS, MSP PRACTITIONER NUMBER

PATIENT SURNAME _____ FIRST NAME _____ INITIAL _____

STREET ADDRESS: _____ TELEPHONE: _____

CITY / TOWN: _____ POSTAL CODE: _____

DOB: YYYY MM DD SEX M F PHYSICIAN'S CHART _____

Locum for physician / MSP Practitioner Number: _____

DIAGNOSIS / CLINICAL INFORMATION (JUSTIFICATION IF GUIDELINE & PROTOCOL IMPACT)

Copy to physician / MSP Practitioner Number: _____

CURRENT MEDICATIONS: _____

HEMATOLOGY	URINE TESTS	CHEMISTRY
<input type="checkbox"/> Hematology profile <input type="checkbox"/> PT-INR <input type="checkbox"/> On warfarin? <input type="checkbox"/> Ferritin (query iron deficiency) Hemochromatosis (✓ ONE box only) <input type="checkbox"/> * Screen (Ferritin first, ± Transferrin Saturation) <input type="checkbox"/> * DNA testing (Requires positive screen or that sibling/parent is confirmed to be homozygous for C282Y/C282Y. Please provide indication in "DIAGNOSIS / CLINICAL INFORMATION" section.)	<input type="checkbox"/> * Urine culture – list current antibiotics: _____ <input type="checkbox"/> * Macroscopic → microscopic if dipstick positive <input type="checkbox"/> * Macroscopic → urine culture if pyuria or nitrite present <input type="checkbox"/> * Macroscopic (dipstick) <input type="checkbox"/> Special case (Justification required if ordered together) <input type="checkbox"/> * Microscopic	<input type="checkbox"/> Glucose – fasting (see reverse for patient instructions) <input type="checkbox"/> Glucose _____ hours post meal <input type="checkbox"/> GTT – gestational diabetes screen (50 g load; 1 hour test) <input type="checkbox"/> GTT – gestational diabetes confirmation (75 g load; fasting, 1, 2 hour tests) <input type="checkbox"/> GTT – non-pregnant (75 g load; 2 hour test) <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Albumin/creatinine ratio (ACR) - Urine

MICROBIOLOGY – label all specimens with patients first & last name, DOB, PHN, & site

ROUTINE CULTURE (Send joint or other body fluids directly to a hospital laboratory.) Current antibiotics: _____ <input type="checkbox"/> Throat <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Superficial Wound, Site: _____ <input type="checkbox"/> Deep Wound, Site: _____ <input type="checkbox"/> Other: _____ VAGINITIS <input type="checkbox"/> Initial (Smear for BV & yeast only) (Requires 1 swab) <input type="checkbox"/> Chronic/recurrent (smear, culture, trichomonas) (Requires 2 swabs) <input type="checkbox"/> Trichomonas testing (Requires 1 swab, 2 if also doing "Initial") GROUP B STREP SCREEN (Pregnancy only) <input type="checkbox"/> Vagino-anorectal swab <input type="checkbox"/> Penicillin allergy CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT Source/site: <input type="checkbox"/> Vagina or Cervix <input type="checkbox"/> Urine GONORRHEA (GC) CULTURE Source/site: <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Throat <input type="checkbox"/> Rectal <input type="checkbox"/> Other: _____ STOOL SPECIMENS History of bloody stools? <input type="checkbox"/> * Yes <input type="checkbox"/> * C. difficile testing <input type="checkbox"/> * Stool culture <input type="checkbox"/> * Stool ova & parasite exam <input type="checkbox"/> * Stool ova & parasite (high risk, 2 samples) DERMATOPHYTES <input type="checkbox"/> Dermatophyte culture <input type="checkbox"/> KOH prep (direct exam) Specimen: <input type="checkbox"/> Skin <input type="checkbox"/> Nail <input type="checkbox"/> Hair Site (be specific): _____ MYCOLOGY <input type="checkbox"/> Yeast <input type="checkbox"/> Fungus Site: _____	HEPATITIS SEROLOGY <input type="checkbox"/> * Acute viral hepatitis undefined etiology Hepatitis A (anti-HAV IgM) Hepatitis B (HBsAg, ± anti-HBc) Hepatitis C (anti-HCV) <input type="checkbox"/> * Chronic viral hepatitis undefined etiology Hepatitis B (HBsAg, anti-HBc, anti-HBs) Hepatitis C (anti-HCV) Investigation of hepatitis immune status <input type="checkbox"/> * Hepatitis A (anti-HAV, total) <input type="checkbox"/> * Hepatitis B (anti-HBs) Hepatitis marker(s) <input type="checkbox"/> * HBsAg (For other hepatitis markers, please order specific test(s) below) <input type="checkbox"/> HIV Serology (Patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting) <input type="checkbox"/> Non-nominal reporting	LIPIDS Tick one box only. For other lipid investigations, please order specific tests below and provide diagnosis. <input type="checkbox"/> * Baseline cardiovascular risk assessment or follow-up (Lipid Profile: Total, HDL, LDL Cholesterol, Triglycerides, fasting) <input type="checkbox"/> * Follow-up of treated hypercholesterolemia (ApoB only, fasting not required) <input type="checkbox"/> * Follow-up of treated hypercholesterolemia (Total, HDL and non-HDL Cholesterol, fasting not required) <input type="checkbox"/> * Self-pay lipid profile (non-MSP billable) THYROID FUNCTION For other thyroid investigations, please order specific tests below and provide diagnosis. <input type="checkbox"/> * Monitor thyroid replacement therapy (TSH Only) <input type="checkbox"/> * Suspected Hypothyroidism (TSH first ± FT4) <input type="checkbox"/> * Suspected Hyperthyroidism (TSH first, ± FT4, ± FT3) OTHER CHEMISTRY TESTS <input type="checkbox"/> Sodium <input type="checkbox"/> Creatinine / eGFR <input type="checkbox"/> Potassium <input type="checkbox"/> Calcium <input type="checkbox"/> Albumin <input type="checkbox"/> Creatine kinase (CK) <input type="checkbox"/> Alk phos <input type="checkbox"/> PSA – Known or suspected prostate cancer <input type="checkbox"/> ALT <input type="checkbox"/> PSA screening (self-pay) <input type="checkbox"/> Bilirubin <input type="checkbox"/> Pregnancy test <input type="checkbox"/> GGT <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> T. Protein
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OTHER TESTS (please print legibly)

* Fecal Occult Blood (Age 50–74 asymptomatic q2y) Copy to Colon Screening Program

Fecal Occult Blood (Other indications)

Standing order requests (expiry & frequency must be indicated)

SIGNATURE OF PHYSICIAN _____ DATE SIGNED _____

HOURS FASTING RX: _____ DATE AND TIME OF LAST DOSE _____ 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. This 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.

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