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 asterix * 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 | PREGNANT? ☐ YES ☐ NO | PHYSICIAN'S CHART

Locum for physician / MSP Practitioner Number:

Copy to physician / MSP Practioner Number:

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

CURRENT MEDICATIONS:

HEMATOLOGY

☐ Hematology profile
☐ PT-INR ☐ On warfarin?
☐ Ferritin (query iron deficiency)

Hemochromatosis (✓ ONE box only)
☐ * Screen (Ferritin first, ± Transferrin Saturation)
☐ * 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.**)

URINE TESTS

☐ * Urine culture – list current antibiotics: _____
☐ * Macroscopic → microscopic if dipstick positive
☐ * Macroscopic → urine culture if pyuria or nitrite present
☐ * Macroscopic (dipstick)
☐ * Microscopic
} ☐ Special case (Justification required if ordered together)

CHEMISTRY

☐ Glucose – fasting (see reverse for patient instructions)
☐ Glucose _____ hours post meal
☐ GTT – gestational diabetes screen (50 g load; 1 hour test)
☐ GTT – gestational diabetes confirmation (75 g load; fasting, 1, 2 hour tests)
☐ GTT - non-pregnant (75 g load; 2 hour test)
☐ Hemoglobin A1c
☐ Albumin/creatinine ratio (ACR) - Urine

LIPIDS
Tick one box only. For other lipid investigations, please order specific tests below and provide diagnosis.

☐ * Baseline cardiovascular risk assessment or follow-up (Lipid Profile: Total, HDL, LDL Cholesterol, Triglycerides, fasting)
☐ * Follow-up of treated hypercholesterolemia (ApoB only, fasting not required)
☐ * Follow-up of treated hypercholesterolemia (Total, HDL and non-HDL Cholesterol, fasting not required)
☐ * Self-pay lipid profile (non-MSP billable)

THYROID FUNCTION
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)

OTHER CHEMISTRY TESTS

☐ Sodium ☐ Creatinine / eGFR
☐ Potassium ☐ Calcium
☐ Albumin ☐ Creatine kinase (CK)
☐ Alk phos ☐ PSA – Known or suspected prostate cancer
☐ ALT ☐ PSA screening (self-pay)
☐ Bilirubin ☐ Pregnancy test
☐ GGT ☐ Serum ☐ Urine
☐ T. Protein

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: _____
☐ Throat ☐ Sputum ☐ Urine
☐ Superficial Wound, Site: _____
☐ Deep Wound, Site: _____
☐ Other: _____

VAGINITIS
☐ Initial (Smear for BV & yeast only) (Requires 1 swab)
☐ Chronic/recurrent (smear, culture, trichomonas) (Requires 2 swabs)
☐ Trichomonas testing (Requires 1 swab, 2 if also doing "Initial")

GROUP B STREP SCREEN (Pregnancy only)
☐ Vagino-anorectal swab ☐ Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT
Source/site: ☐ Vagina or Cervix ☐ Urine

GONORRHEA (GC) CULTURE
Source/site: ☐ Cervix ☐ Urethra ☐ Throat ☐ Rectal ☐ Other: _____

STOOL SPECIMENS
History of bloody stools? ☐ * Yes
☐ * *C. difficile* testing
☐ * Stool culture
☐ * Stool ova & parasite exam
☐ * Stool ova & parasite (high risk, 2 samples)

DERMATOPHYTES
☐ Dermatophyte culture ☐ KOH prep (direct exam)
Specimen: ☐ Skin ☐ Nail ☐ Hair
Site (be specific): _____

MYCOLOGY
☐ Yeast ☐ Fungus Site: _____

HEPATITIS SEROLOGY

☐ * **Acute viral hepatitis undefined etiology**
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg, ± anti-HBc)
Hepatitis C (anti-HCV)

☐ * **Chronic viral hepatitis undefined etiology**
Hepatitis B (HBsAg, anti-HBc, anti-HBs)
Hepatitis C (anti-HCV)

Investigation of hepatitis immune status
☐ * Hepatitis A (anti-HAV, total)
☐ * Hepatitis B (anti-HBs)

Hepatitis marker(s)
☐ * HBsAg
(For other hepatitis markers, please order specific test(s) below)

☐ **HIV Serology**
(Patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting)
☐ Non-nominal reporting

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)