VALLEY MEDICAL / OKANAGAN CLINICAL LABORATORIES
HOUSE CALL REQUEST FORM (rev 2019-04)

(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 at the bottom of front page.**

2. **Please FAX the completed form to the appropriate number above.**

VALLEY MEDICAL LABORATORIES
OKANAGAN CLINICAL LABORATORIES
www.valleymedicallaboratories.com

(2019-02)

HOUSE CALL REQUISITION

LAB
DEMO
LABEL

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

For tests indicated with a blue tick box, 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:

If this is a STAT order, please provide contact telephone number: ____________

DOB: YYYY MM DD | SEX ☐ M ☐ F | PREGNANT? ☐ YES ☐ NO | HOURS FASTING

Locum for physician / MSP Practitioner Number:

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

Copy to physician / MSP Practioner Number:

CURRENT MEDICATIONS: | DATE AND TIME OF LAST DOSE:

HEMATOLOGY

- ☐ Hematology profile
- ☐ INR
- ☐ Ferritin (query iron deficiency)

On Anticoagulant? ☐ Yes ☐ No
Specify: ____________

HFE - Hemochromatosis (check ONE box only)
- ☐ Confirm diagnosis (ferritin first, ± TS, ± DNA testing)
- ☐ Sibling/parent is C282Y/C282Y homozygote (DNA testing)

URINE TESTS

- ☐ Macroscopic → microscopic if dipstick positive
- ☐ Macroscopic → urine culture if pyuria or nitrite present
- ☐ Macroscopic (dipstick) ☐ Microscopic *

* Clinical information for microscopic required: ____________

CHEMISTRY

- ☐ Glucose – fasting
- ☐ Glucose – random
- ☐ GTT – gestational diabetes screen (50 g load, 1 hour post-load)
- ☐ GTT – gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test)
- ☐ GTT – non-gestational diabetes
- ☐ Hemoglobin A1c
- ☐ Albumin/creatinine ratio (ACR) - Urine

MICROBIOLOGY – LABEL ALL SPECIMENS WITH PATIENT'S FIRST & LAST NAME, DOB, PHN & SITE

ROUTINE CULTURE (Send Joint and other body fluids directly to a hospital laboratory)

On Antibiotics? ☐ Yes ☐ No Specify: ____________

- ☐ Throat ☐ Sputum ☐ Urine
- ☐ Superficial Wound, Site: ____________
- ☐ Deep Wound, Site: ____________
- ☐ Other: ____________

VAGINITIS
- ☐ Initial (smear for BV & yeast only)
- ☐ Chronic/recurrent (smear, culture, trichomonas NAAT)
- ☐ Trichomonas testing NAAT

Trichomonas NAAT – may use CT/GC sample (urine or swab)

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

CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT
Source/site: ☐ Urethra ☐ Cervix ☐ Urine ☐ Vagina ☐ Throat ☐ Rectum
Other ____________

GONORRHEA (GC) CULTURE
Source/site: ☐ Cervix ☐ Urethra ☐ Throat ☐ Rectum
Other ____________

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

DERMATOPHYTES
- ☐ Dermatophyte culture ☐ KOH prep (direct exam)

Specimen: ☐ Skin ☐ Nail ☐ Hair

Site: ____________

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
- ☐ ECG available Vernon Downtown & Penticton Labs Only
- ☐ FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program
- ☐ FIT No copy to Colon Screening Program

LIPIDS

✓ one box only

Note: Fasting is not required for any of the panels but clinician may specifically instruct patient to fast for 10 hours in select circumstances [e.g. history of triglycerides > 4.5 mmol/L], independent of laboratory requirements.

- ☐ Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia)
- ☐ Follow-up Lipid Profile - Total, HDL & non-HDL cholesterol only
- ☐ Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated)

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 if indicated)
- ☐ Suspected Hyperthyroidism (TSH first, fT4 & fT3 if indicated)

OTHER CHEMISTRY TESTS
- ☐ Sodium
- ☐ Potassium
- ☐ Albumin
- ☐ Alk phos
- ☐ ALT
- ☐ B12
- ☐ Bilirubin
- ☐ GGT
- ☐ T. Protein
- ☐ Creatinine / eGFR
- ☐ Calcium
- ☐ Creatine kinase (CK)
- ☐ PSA – Known or suspected prostate cancer (MSP billable)
- ☐ PSA screening (self-pay)
- ☐ Pregnancy test
- ☐ ß-HCG – quantitative

SIGNATURE OF PRACTITIONER | DATE SIGNED

DATE OF COLLECTION | TIME OF COLLECTION | COLLECTOR | 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.

HLTH 1901 2019/02

☐ 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):