

BIOCHEMISTRY

Referred-in Client Requisition

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

REFERRING LABORATORY:

Name: _____	Address: _____	Telephone: _____
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PHONE RESULTS TO:

Telephone: _____	Fax: _____
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Ordering Physician: _____

SPECIMEN INFORMATION

Collection Date: _____ (DD/MM/YYYY)	Collection Time: _____ (hh:mm)	Referring Specimen/Reference #: _____
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STORAGE / TRANSPORTATION

Send specimens frozen unless otherwise specified.

Test Name	Specimen Requirements
<input type="checkbox"/> 11-Deoxycortisol, Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> 17-Hydroxy Progesterone, Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> 21-HydroxyProgesterone, Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Alpha-fetoprotein (AFP), Blood	150 uL Serum
<input type="checkbox"/> Androstenedione, Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Anti-TPO, Blood	150 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Breath Hydrogen	20 cc Expired Air (Contact lab before sending)
<input type="checkbox"/> Carotene, Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Chylomicrons in Fluids - ChyloThorax Investigation	300 uL Fluid samples (e.g., pleural, peritoneal, chest drainage) (Send cold with ice packs)
<input type="checkbox"/> Corticosterone, Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Cortisol, Blood	400 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> DHEA-S, Blood	1mL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Estradiol (Sensitive), Blood	500 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Fecal Elastase, Stool	10 g Random stool
<input type="checkbox"/> Fecal Fat, Stool	100 g Feces (Contact lab before sending)
<input type="checkbox"/> Ferritin, Blood	150 uL Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Folate, Serum and RBC	150 uL Serum, Protect from light, EDTA for RBC Folate
<input type="checkbox"/> Free Fatty Acid, Blood	150 uL Serum
<input type="checkbox"/> FSH, Blood	150 uL Serum, Plasma (Lithium Heparin)

Received Date & Time:

LABORATORY USE ONLY
 SickKids Lab #:

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<input type="checkbox"/> Growth Hormone, Blood	250 uL	Serum
<input type="checkbox"/> hCG (Total B-hCG), Blood (Pregnancy)	150 uL	Serum
<input type="checkbox"/> hCG (Total B-hCG), Blood (Tumor marker)	150 uL	Serum
<input type="checkbox"/> Homocysteine, Blood	300 uL	Serum, Plasma (Lithium Heparin / K-EDTA)
<input type="checkbox"/> Homovanillic Acid (HVA), Urine	20 mL	Urine
<input type="checkbox"/> IGF-1, Blood	200 uL	Serum
<input type="checkbox"/> Insulin, Blood	250 uL	Serum, Plasma (Sodium / Lithium Heparin)
<input type="checkbox"/> Intralipid, Blood	200 uL	Serum (<u>Do not freeze. Send in ice packs</u>)
<input type="checkbox"/> LH, Blood	150 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Osmolarity, Blood	60 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Pancreatic Amylase, blood	200 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Plasma Haemoglobin, Blood	1200 uL	Plasma (Lithium Heparin)
<input type="checkbox"/> Progesterone, Blood	500 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Prolactin, Blood	150 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> PTH - Intact, Blood	300 uL	Serum
<input type="checkbox"/> Renin, Direct, Blood	1 mL	EDTA plasma
<input type="checkbox"/> Soluble Transferrin Receptor	250 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Sweat Chloride	40 uL	Sweat
<input type="checkbox"/> T3 - Total, Blood	150 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> T4 - Free, Blood	150 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Testosterone, Blood	300 uL	Serum
<input type="checkbox"/> TSH, Blood	300 uL	Serum, Plasma (Sodium / Lithium Heparin)
<input type="checkbox"/> Vanillylmandelic Acid (VMA), Urine	20 mL	Urine
<input type="checkbox"/> Vitamin A, Blood	300 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Vitamin B12, Blood	150 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Vitamin D2 and D3, Blood	300 uL	Serum, Plasma (Lithium Heparin)
<input type="checkbox"/> Vitamin E, Blood	300 uL	Serum, Plasma (Lithium Heparin)

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BILLING FORM

The hospital, referring laboratory, or a patient/guardian will be billed for the services rendered.

- Invoices are sent upon completion of each test/service.
- Contact SickKids' Laboratory at 416-813-7200 with billing inquiries.

How to complete the Billing Form: (Completion of Billing Form NOT required for patients with an Ontario Health Card Number.)

- Referring Physician completes the appropriate section below to specify billing method.
- Send requisition and completed "Billing Form" with specimen.

Option 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory:
 Name: _____ Address: _____

 City: _____ Prov/State: _____
 Postal/Zip Code: _____ Country: _____
 Contact Name: _____
 Contact Telephone #: _____

Option 2: Interm Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.

UCI# _____
 ICD code (lab use only): _____

Option 3: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.
- Please advise the patient/guardian to expect a bill from our laboratory.
- Provide us with patient's valid credit card information.
- Unfortunately, we cannot accept personal checks.
- **In this case, the patient/guardian is solely responsible for the charges.**

Relation to patient (check one): Patient Guardian/Parent

Method of Payment (check one): American Express MasterCard Visa

Name as it appears on credit card: _____

Credit card #: _____

Expiry date on credit card: _____

CVS#- found on back of card (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____
 Address: _____
 _____ Apt. #: _____
 City: _____ Prov/State: _____
 Postal/Zip Code: _____ Country: _____

Additional Contact Information

Patient's phone # with area code: _____

- or -
 Guardian's phone # with area code: _____