

MICROBIOLOGY LABORATORY

555 University Avenue
 Room 3676, Atrium
 Toronto, ON, M5G 1X8, Canada

Tel: 416-813-6000
 Fax: 416-813-5993

Patient Last Name: _____

First Name: _____

Date of Birth (DD/MM/YYYY): _____

Gender: Male Female

For Canada Only

Provincial Health Card #: _____

Version: _____

Issuing Province: _____

QUANTIFERON TB (QFT)

Referred-in Client Requisition

<p>Testing Requested by Public Health Unit: <input type="checkbox"/> TPH Pilot - iPHIS ID: _____</p>	<p>Mailing Address: <div style="border: 1px solid black; height: 50px; width: 100%;"></div></p>
<p>Referring Physician Hospital (specify): _____ Doctor's Office: _____ Referring Laboratory: _____ Referring Lab Accession #: _____</p>	<p>Telephone Number: _____ Fax Number: _____</p>

Specimen Collection Information

Date (DD/MM/YYYY): _____	Time (HH:MM): _____	Collected By: _____
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Shipping Instructions

All specimens that DO NOT MEET the transport requirements will be REJECTED.

Optimal Collection Time / Storage / Transportation / Receipt of Samples

Blood Collection Tube: 6mL Lithium - heparin tube (green top/white label).

- Tubes should be between room temperature (17–25°C) at the time of blood filling.
- Only a Lithium - heparin anticoagulant is acceptable.

Blood collection: Collect a minimum volume of 5 mL of blood into a **single** Lithium - heparin tube.

- Gently mix by inverting several times to dissolve the heparin.
- Blood must first be held at room temperature (17–25°C) for a minimum of 15 minutes and a maximum of 3 hours before being placed in the refrigerator (2–8°C).
- Specimen may be held in the refrigerator for a further 16 to 48 hours before shipping.

Shipping to SickKids Microbiology:

- Ship on ice packs.
- Total time from collection to receipt in SickKids Microbiology laboratory **cannot** exceed 50 hours.

Specimen Shipping & Receipt / Handling at SickKids:

- Specimens should be shipped Monday to Friday and received at SickKids by 5pm.
 - Deliver to: Microbiology Laboratory, room 3676, 3rd floor Atrium.
 - Specimens will be transferred to QFT – Plus Blood Collection Tubes on receipt.
- After hours: Deliver specimens to the Rapid Response Laboratory room 3642.

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Risk Factors for TB Infection

Birthplace: Child _____ Mother _____ Father _____

Last travel outside Canada: Date (MM/YYYY) _____ Country _____

Prior BCG: Yes, Date (DD/MM/YYYY) _____ No Unknown

Indication

1) Known contact of TB that is:
 Fully Sensitive Sensitivity Unknown Multi-Drug Resistant (MDR) Resistant to one agent _____
 Break in Contact from Index Case was (DD/MM/YYYY) _____

2) Suspected of having active TB disease No Yes

3) Prior Treatment for TB disease No Yes Date (MM/YYYY) _____

4) Immunocompromised No Yes Condition _____

5) Pre Biologic No Yes Underlying Condition _____

6) Other _____

Tuberculosis Skin Test (TST) Result

Skin Test Planted (DD/MM/YYYY)	Skin Test Read (DD/MM/YYYY)	Result (mm of induration)
1st test:	1st test:	1st test:
2nd test:	2nd test:	2nd test:

QFT Specimen Information

Date/Time Received	Aliquot into QFT tubes	Incubated:
Centrifuged	Test Date	

Blank area for notes or additional information.

Internal Use Only

Microbiologist Review _____

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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:

Option 2: Interim Federal Health Program (IFHP)

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory:

Name: _____

Address: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Contact Name: _____

Contact Telephone #: _____

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: _____

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