

### Section 1 - Patient Information

<b>PERSONAL HEALTH NUMBER</b> (or out-of province Health Number and province)	<b>DOB</b> (DD/MMM/YYYY)	<b>GENDER</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK
<b>PATIENT SURNAME</b>	<b>PATIENT FIRST AND MIDDLE NAME</b>	
<b>ADDRESS</b>	<b>CITY</b>	<b>POSTAL CODE</b>

DATE RECEIVED
<b>PHSA LABORATORIES USE ONLY</b>
OUTBREAK ID

### Section 2 - Healthcare Provider Information

<b>ORDERING PHYSICIAN</b> (Provide MSC#) Name and address of report delivery	<b>ADDITIONAL COPIES TO:</b> (Address / MSC#)  1.  2.  3.
<input type="checkbox"/> I do not require a copy of the report	
<b>CLINIC OR HOSPITAL</b> Name and address of report delivery	
<b>PHSA CLIENT NO.</b>	

<b>SAMPLE REF. NO.</b>
<b>DATE COLLECTED</b> (DD/MMM/YYYY)
<b>TIME COLLECTED</b> (HH:MM)

### Section 3 - Test(s) Requested

VIRUSES	BACTERIA	PARASITES
<input type="checkbox"/> Arbovirus Panel Eastern Equine Encephalitis, Western Equine Encephalitis, Powassan, St. Louis Encephalitis  <input type="checkbox"/> Dengue Virus Antibody  <input type="checkbox"/> Hanta Virus Antibody  <input type="checkbox"/> West Nile Virus Antibody  <input type="checkbox"/> Other, specify: _____  <b>Travel / Clinical History Required for Above Tests:</b> _____ _____  <b>Signs / Symptoms</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Insect bite: _____ <input type="checkbox"/> Skin rash: _____ Type/Location _____ <input type="checkbox"/> Neurological <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Anti-Streptolysin O (ASO)  <input type="checkbox"/> <i>Bartonella henselae</i> Antibody  <input type="checkbox"/> <i>Borrelia burgdorferi</i> (Lyme disease) Antibody  <input type="checkbox"/> <i>Borrelia hermsii</i> Antibody  <input type="checkbox"/> <i>Brucella abortus</i> Antibody  <input type="checkbox"/> <i>Coxiella burnetii</i> (Q-fever) Antibody  <input type="checkbox"/> <i>Francisella tularensis</i> Antibody  <input type="checkbox"/> <i>Helicobacter pylori</i> Antigen (Feces)  <input type="checkbox"/> <i>Legionella</i> species Urine Antigen  <input type="checkbox"/> <i>Leptospira</i> Antibody  <input type="checkbox"/> <i>Rickettsia rickettsii</i> Antibody (Rocky Mountain Spotted Fever)  <input type="checkbox"/> TB Interferon Gamma Release Assay* <input type="checkbox"/> TST Positive <input type="checkbox"/> TST Negative  <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> <i>Echinococcus</i> Antibody  <input type="checkbox"/> <i>Entamoeba histolytica</i> (Amoebiasis) Antibody  <input type="checkbox"/> <i>Schistosoma</i> Antibody  <input type="checkbox"/> <i>Strongyloides</i> Antibody  <b>Travel History Required for Above Tests:</b> <input type="checkbox"/> Travel within past 12 months, specify: _____ _____  <input type="checkbox"/> <i>Leishmania</i> Antibody  <input type="checkbox"/> <i>Toxoplasma gondii</i> Antibody  <input type="checkbox"/> <i>Trichinella</i> Antibody  <input type="checkbox"/> <i>Trypanosoma cruzi</i> (American trypanosomiasis) Antibody  <input type="checkbox"/> Other, specify: _____
<b>SYPHILIS</b>  <input type="checkbox"/> VDRL (CSF sample only) Submit 1 mL CSF in sterile leak-proof tube  <input type="checkbox"/> <i>Treponema pallidum</i> Nucleic Acid Testing* Submit exudate, tissue or body fluid  <input type="checkbox"/> Darkfield (DF) Microscopy Source of sample: _____  <input type="checkbox"/> Direct Fluorescent Assay (DFA) Microscopy Source of sample: _____  <b>Signs / Symptoms</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Rash  <input type="checkbox"/> Other, specify: _____	<b>FUNGI</b>  <input type="checkbox"/> <i>Blastomyces dermatidis</i> Antibody  <input type="checkbox"/> <i>Coccidioides</i> species Antibody  <input type="checkbox"/> <i>Cryptococcus neoformans</i> Antigen  <input type="checkbox"/> <i>Histoplasma</i> Antibody  <input type="checkbox"/> Other, specify: _____  <b>Travel History Required for Above Tests:</b> <input type="checkbox"/> Travel within past 12 months, specify: _____ _____	<p><b>* CONSULTATION REQUIRED</b></p> <p>Please telephone Program Head (Medical Microbiologist) at (604) 707-2622</p> <p>For other available tests and additional information, consult the Public Health Microbiology &amp; Reference Laboratory's <i>Guide to Programs and Services</i> at <a href="http://www.phsa.ca/bccdcpublichealthlab">www.phsa.ca/bccdcpublichealthlab</a></p>

# PHSA Laboratories

Public Health Microbiology & Reference Laboratory

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