SickKids
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

Division of Biochemistry
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-5431

Patient Name:
Date of Birth (DD/MM/YYYY):
Sex Assigned at Birth: ○*Male* ○*Female* ○*Unassigned*
Legal Sex (if different): ○*Male* ○*Female* ○*Non-binary/U/X*
Gender Identity: ○*Male* ○*Female* ○*Non-binary/U/X*
Parent's Name:
Address:

For Canada Only
Health Card #:
Issuing Province:
Version

TOXICOLOGY

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.

☐ **Priority** ☐ **STAT** ☐ **Routine**

Referring Laboratory	Phone: Fax:
Name	Email:
Address	Ordering Physician

CLINICAL INFORMATION

Toxidrome		Suspected Drugs, Mode and Time of Intake:
Please indicate how the patient presented:		
❑ SEDATIVE HYPNOTIC	❑ STIMULANT	Medication Given or Prescribed:
❑ COMA - APNEA - SEIZURE	❑ HALLUCINOGENIC	
❑ ANTICHOLINERGIC	❑ UNKNOWN	

Brief Medical History:

SPECIMEN AND REQUEST INFORMATION

❑ **BLOOD** (10 mL clotted required)

Collection date and time

_____-_____-_____ _____:____h
(DD-MM-YYYY) (hh:mm)

Your Specimen #

BLOOD TESTS REQUESTED:

❑ **Volatiles Quantitation**
(Ethanol, Methanol, Isopropanol, Acetone)

Glycol Quantitation
- ❑ *Ethylene Glycol*
- ❑ *Propylene Glycol*
- ❑ *Diethylene Glycol*

❑ **Barbiturates and Other Sedatives**

Analgesics
- ❑ Acetaminophen
- ❑ Ibuprofen
- ❑ Salicylate

Psychotropic Drugs *(included in Broad Spectrum Drug Screen)*
- ❑ Benzodiazepine Screen
- ❑ Tryciclic Anti-depressant Screen

Date Rape Drugs
- ❑ Gamma Hydroxy Butyrate *(GHB)*

❑ **Broad Spectrum Drug Screen**

❑ **URINE** (10 mL required)

Collection date and time

_____-_____-_____ _____:____h
(DD-MM-YYYY) (hh:mm)

Your Specimen #

URINE TESTS REQUESTED:

❑ **Broad Spectrum Drug Screen**

❑ **Benzodiazepine Screen Identification**
(included in Broad Spectrum Drug Screen)

All tests below are not included in the Broad Spectrum Drug Screen

❑ **Barbiturate Screen**

❑ **Cannabinoid Screen**

❑ **Ethanol**

Date Rape Drugs
- ❑ Gamma Hydroxy Butyrate *(GHB)*

❑ **Other Tests**

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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.

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:_____

CVC#- 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:

_____