SickKids
THE HOSPITAL FOR SICK CHILDREN

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

Testing Requested by Public Health Unit:
☐ Toronto ☐ Other (specify): ____________________

☐ TPH Pilot - iPHIS ID: ____________________

Mailing Address:

Referring Physician

Hospital *(specify)*: ____________________

Doctor's Office: ____________________

Referring Laboratory: ____________________

Referring Lab Accession #: ____________________

Telephone Number: ____________________

Fax Number: ____________________

Specimen Collection Information

Date (DD/MM/YYYY): ____________________

Collected By: ____________________

Time (HH:MM): ____________________

Telephone Number (TPH Pilot): ____________________

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	

Internal Use Only

Microbiologist Review____________ Refmoh (____)

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BILLING FORM

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, CPT code, test name and charge.
- Contact SickKids' Genome Diagnostics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

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

Section 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: ____________________

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: ____________________
Address: ____________________
City: ____________________ Prov/State: ____________________
Postal/Zip Code: ____________________ Country: ____________________

Contact Name: ____________________ Contact Telephone #: ____________________

Section 2: 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.***

Send bill to (check one): ☐ Patient ☐ Guardian

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

Name as it appears on credit card: ____________________

Credit card # : ____________________

Expiry date on credit card: ____________________

Signature of credit card holder (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:
____