SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

TOXICOLOGY & THERAPEUTIC DRUG MONITORING SERVICE
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada
Tel: 416-813-7200
Fax: 416-813-6211

MRN:
Last Name:
First Name:
Gender : ☐ *Male* ☐ *Female*
Date of Birth (DD/MM/YYYY):

ANTIRETROVIRAL THERAPEUTIC DRUG MONITORING PROGRAM

Antiretroviral Requisition

For Outside SickKids:	**For Within SickKids:**
Referring Physician:	Ordering Physician:
Referring Institution:	Registration #:
Mailing Address:	
Phone Results to: Tel # : Fax #:	Patient Location:

Patient Information: Weight: _____ kg Height: _____ m Pregnancy: ☐ No ☐ Yes # weeks gestation: _____

Last viral load: _____ cpm Date: _____ Last CD4 count: _____ Date: _____

Genotype (please attach): _____

Reason for Therapeutic Drug Monitoring (please check all that apply)

☐ Virological Failure	☐ Suspicion of intoxication	☐ Paediatrics
☐ Drug Interaction	☐ Hepatic impairment	☐ Once-daily dosing
☐ Suspicion of non-adherence	☐ Suspected malabsorption	☐ Validation post-dosage adjustment
☐ Other (specify):		

Current other medications *(drug names):*

Drug(s) to be monitored (check all that apply)

Collection Date & Time

DD/MM/YYYY: _____ HH:MM: _____

	Drug Name	Date & Time of Last Dose (DD/MM/YYYY) (hh:mm)	Dose mg
☐	Amprenavir		
☐	Atazanavir		
☐	Darunavir		
☐	Efavirenz		
☐	Etravirine		
☐	Indinavir		
☐	Lopinavir		
☐	Maraviroc		
☐	Nelfinavir		
☐	Nevirapine		
☐	Raltegravir		
☐	Ritonavir		
☐	Saquinavir		
☐	Tipranavir		

Blood Collection

- **Preferred collection time** is a pre-dose trough sample (0 – 30 minutes prior to next dose)
- If this is not possible, the blood may be collected at the **times indicated in the chart on the right:**

Frequency	Collection Time
Twice daily dosing	6 – 14 hours post dose
Once daily dosing	12 – 26 hours post dose
Efavirenz	≥ 10 hours post dose

- **Peak collection times** are indicated in the chart below:

Collection Time	Drug(s)
2 – 4 hours post dose	Amprenavir, Atazanavir, Darunavir, Indinavir, Nelfinavir, Nevirapine
4 – 6 hours post dose	Efavirenz, Lopinavir

Sample Type

Note: DO NOT use blood collection tubes that contain a gel

- One heparinized (green top) 5 mL collection tube is required
- Minimum volume (for children) is 3 mL heparinized blood
- Centrifuge within 2 hours of collection and transfer the plasma to a clean tube
- If the sample is being shipped the same day store the sample at 4° C
- For longer term storage, the plasma should be frozen at -20° C until shipped
- Transport with a cold pack

Specimen Transport

- Samples should be sent Monday to Thursday, to ensure receipt in the laboratory before the weekend

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Antiretroviral Requisition 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:

_____