SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

RAPID RESPONSE LABORATORY
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada
Tel: 416-813-7200
Fax: 416-813-5431

Patient Surname:
First Name:
History / Client / MRN #:
Date of Birth (DD/MM/YYYY):
Gender: ☐ *Male* ☐ *Female*

For Canada Only
Provincial Health Card # *Version:*
Issuing Province:

IMMUNOLOGY

Referred-in Client Requisition

REFERRING PHYSICIAN / INSTITUTION

Name:	Address:	Telephone:

PHONE RESULTS TO:

Telephone:	Fax:

SPECIMEN INFORMATION

Collection Date: (DD/MM/YYYY)	Collection Time: (hh:mm)	Referring Specimen/Reference #:

CLINCAL INFORMATION/DIAGNOSIS

TEST(S) REQUESTED		SPECIMEN REQUIREMENTS
☐	CD163	• EDTA plasma (2 aliquots of 0.3mL plasma each) • Centrifuge for 15 minutes at 1000 RCF within 15 minutes of collection • Immediately separate and freeze. • Send specimens frozen and avoid freeze/thaw cycles **NOTE** If ordering multiple cytokines at a time, minimum volume required is as follows: • any combination of: TNF-alpha, CXCL9/MIG1, IFN-gamma, CD163 ==> 2 tubes of 0.3 mL each • any combination of: IL-10, IL-18, IL-1beta and IL-6 ==> 2 tubes of 0.3 mL each
☐	CXCL9/MIG	
☐	IFN-Gamma	
☐	Interleukin 1 Beta	
☐	Interleukin 10	
☐	Interleukin 18	
☐	Interleukin 6	
☐	TNF-alpha	
☐	Soluble IL-2 Receptor Level (CD25)	• EDTA plasma (2 aliquots of 0.3mL plasma each) • Store samples at -20°C in polypropylene tubes. • Ship frozen. Avoid freeze/thaw cycles. • Do not store samples in glass. • Avoid samples with gross hemolysis or lipemia.

LABORATORY USE

_____-_____Date/time received (yyyy-mm-dd) / hh:mm SickKids Lab#

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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:

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: _____

CVV#- 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:

_____