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: 416-813-5906
Fax: 416-813-6211

# DRUG FACILITATED SEXUAL ASSAULT

**Referred-in Requisition**

**Urgency** ☐ **STAT** ☐ **Routine**

*Last Name:*
*First Name:*
*Date of Birth (DD/MM/YYYY):*
*Gender:* ☐ *Male* ☐ *Female*
*Ontario Health Card #:* *Version:*
*History / Client #:*

**Referring Physician:**
**Referring Institution:**
**Address:**
**Phone Results to:**
**Tel #:** **Fax #:**

## CLINICAL INFORMATION

**Drug Facilitated Sexual Assault**

Please indicate samples submitted for testing:

☐ Blood only

☐ Urine only

☐ Blood & Urine

Suspected Drugs, Mode and Time of Intake:

Medications Given or Prescribed:

Brief Medical History:

## SPECIMEN REQUEST & PANEL INFORMATION

☐ **BLOOD** (10 mL clotted required)

Collection:

Date (DD-MM-YYYY) Time (hh:mm)

Your Specimen # _____

**Blood Panel**

- Broad Spectrum Drug Screen
- Barbiturate/Sedative Screen
- Benzodiazepine Screen/Identification *(included in Broad Spectrum Drug Screen)*
- Volatile Screen *(Ethanol, Methanol, Isopropanol, Acetone)*
- GHB

SickKids Lab # _____

☐ **URINE** (10 mL required)

Collection:

Date (DD-MM-YYYY) Time (hh:mm)

Your Specimen # _____

**Urine Panel**

- Broad Spectrum Drug Screen
- Barbiturate Screen
- Benzodiazepine Screen/Identification *(included in Broad Spectrum Drug Screen)*
- THC Screen
- Volatile Screen *(Ethanol, Methanol, Isopropanol, Acetone)*
- GHB

SickKids Lab # _____

**Blood & Urine Panel**

- Broad Spectrum Drug Screen – urine
- Barbiturate Screen - urine
- Benzodiazepine Screen/Identification - urine *(included in Broad Spectrum Drug Screen)*
- THC - urine
- GHB - urine
- Volatile Screen *(Ethanol, Methanol, Isopropanol, Acetone)* – blood
- Barbiturate/Sedative Screen – blood
- Benzodiazepine Screen/Identification – blood

**LABORATORY USE ONLY**

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## DRUG FACILITATED SEXUAL ASSAULT

**Referred-in 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: _____

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:

_____