



THE HOSPITAL FOR
SICK CHILDREN

Paediatric
Laboratory Medicine

**METABOLIC DISEASES
LABORATORY**

555 University Avenue
Room 3333, Black
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-6599

Last Name:

First Name:

Birth Date (YYYY-MM-DD):

Gender: Male Female Unknown

For Canada Only

Health Card #:

Issuing Province:

Version:

ANALYTES

Referred-in Client Requisition

SPECIMEN COLLECTION INFORMATION

Date (YYYY-MM-DD)

Time (HH:MM)

Referring Physician / Institution

Name:	Address
Telephone:	
Referring Lab Accession #:	

Clinical Information/Diagnostic Indications (essential for adequate evaluation of test results)

Special Diet: No Yes (medium-chain triglycerides No Yes)

Exclusion of specific diagnosis: No Yes - Details: _____

Follow-up/Repeat changes: No Yes - Details: _____

PLEASE NOTE: The test codes below are SAMPLE TYPE SPECIFIC

p = plasma; s = serum; u = urine

Screens			Analytes Test Menu					
Blood			Blood		CSF			
<input type="checkbox"/>	YGALS	Galactosemia Screen, whole blood (GAL-1-PUT screen)**	<input type="checkbox"/>	YQACY	Acylcarnitine, quantitative, p, s	<input type="checkbox"/>	YQAAFF	Amino acids, quantitative, csf
			<input type="checkbox"/>	YQAAA	Amino acids, quantitative, p, s	<input type="checkbox"/>	YBHBFB	Beta-Hydroxybutyrate, csf
			<input type="checkbox"/>	YBHB	Beta-Hydroxybutyrate, p, s	<input type="checkbox"/>	YPYRF	Pyruvate, csf
Urine			<input type="checkbox"/>	YBTIN	Biotinidase, s, p			
<input type="checkbox"/>	ZGCLU	Glycolipids TLC, u	<input type="checkbox"/>	YFCRN YCRN	Carnitine Free & Total, s, p	Urine		
<input type="checkbox"/>	ZMPSU	Mucopolysaccharides Screen, u	<input type="checkbox"/>	YCDGT	CDG Transferrin, s	<input type="checkbox"/>	YQAAUU	Amino acids, quantitative, u
<input type="checkbox"/>	ZMPTU	Mucopolysaccharides TLC, u (available only if screen is positive otherwise, please specify reason: _____ _____ _____)	<input type="checkbox"/>	YFFA	Free Fatty Acid, s	<input type="checkbox"/>	YFCRNU YCRNU	Carnitine Free & Total, u
<input type="checkbox"/>	ZOGO	Oligosaccharides, u	<input type="checkbox"/>	HMC	Homocysteine, p, s	<input type="checkbox"/>	YCDPU	Creatine/Guanidinoacetate panel, u
<input type="checkbox"/>	ZOGSAU	Sialic Acid TLC, u	<input type="checkbox"/>	YPOXA	Oxalic acid, p	<input type="checkbox"/>	YHYOXU	Hyperoxaluria panel, u
<input type="checkbox"/>	YSIDU	Sugar Identification TLC, u	<input type="checkbox"/>	YPYR	Pyruvate, s	<input type="checkbox"/>	YORGU	Organic Acid, u
			Blood Spot (filter paper)		<input type="checkbox"/>	YOROU	Orotic Acid, u	
			<input type="checkbox"/>	YMSUDB	Valine, Leucine, Alloisoleucine, IsoLeucine, blood spot	<input type="checkbox"/>	YSAU	Succinylacetone, u
			<input type="checkbox"/>	YPHEB YTYRB	Phenylalanine and Tyrosine, blood spot	<input type="checkbox"/>	YSULU	Sulfatides, u
						<input type="checkbox"/>	YSCU	Sulfocysteine, u

**For patients > 18 years of age, please provide clinical indications

For alternative sample types or diseases not listed above, please contact the Customer Service at 416-813-7200 and request a consult with a Metabolic Diseases' staff member.

Disease Name: _____

Alternative Sample Type: _____

Last Name: _____

First Name: _____

Birth Date (YYYY-MM-DD): _____

Gender: Male Female Unknown

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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' 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.**

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 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): _____

Option 2: Interim Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible.

- Only eligible verified IFHP will be accepted.
- Eligible patients are issued one of two possible IFHP eligibility documents: a Refugee Protection Claimant Document (with photo) (RPCD) or an Interim Federal Health Program Certificate (IFHC).
- All documentation must be current with acceptable client information, client ID (UCI #), expiry date, IFHP Effective date, IFHP expiry date, signature and photo.
- Specimens without proper documentation will NOT be accepted.

For additional details on the IFHP program, visit www.cic.gc.ca/ifhp.

UCI# _____

ICD code (lab use only): _____

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: _____