



THE HOSPITAL FOR
SICK CHILDREN

Paediatric
Laboratory Medicine

**METABOLIC DISEASES
LABORATORY**

555 University Avenue
Room 3333, Atrium
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:

METABOLIC DISEASES - LYSOSOMAL ENZYMES

Referred-in Client Requisition

SPECIMEN COLLECTION INFORMATION

Date (YYYY-MM-DD)

Time (HH:MM)

Referring Physician / Institution

Name:

Telephone:

Referring Lab Accession #:

Address

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

PLEASE NOTE: The test codes below are SAMPLE TYPE SPECIFIC.

fib = fibroblasts; p = plasma; s = serum; wbc = leukocytes

LYSOSOMAL ENZYME ANALYSIS TEST MENU

Alpha-Mannosidosis		I-CELL Disease Lysosomal Hydrolases		Sanfilippo Disease, Type A	
<input type="checkbox"/>	ZAMNR Alpha-Mannosidase, fib	<input type="checkbox"/>	ZHEXB Beta Hexosaminidase, s	<input type="checkbox"/>	ZSFAR Sanfilippo A Enzyme, fib
<input type="checkbox"/>	ZAMNW Alpha-Mannosidase, wbc	Krabbe Leukodystrophy		Sanfilippo Disease, Type B	
Beta-mannosidosis		<input type="checkbox"/>	ZGCRR Galactocerebrosidase, fib	<input type="checkbox"/>	ZSFBB Sanfilippo B Enzyme, s, p
<input type="checkbox"/>	ZBMNR Beta-Mannosidase, fib	<input type="checkbox"/>	ZGCRW Galactocerebrosidase, wbc	<input type="checkbox"/>	ZSFBR Sanfilippo B Enzyme, fib
<input type="checkbox"/>	ZBMNW Beta-Mannosidase, wbc	Maroteaux-Lamy Disease		<input type="checkbox"/>	ZSFBW Sanfilippo B Enzyme, wbc
Fucosidosis		<input type="checkbox"/>	ZASBR Aryl Sulfatase B, fib	Sanfilippo Disease, Type C	
<input type="checkbox"/>	ZFUCR Alpha-Fucosidase, fib	<input type="checkbox"/>	ZASBW Aryl Sulfatase B, wbc	<input type="checkbox"/>	ZSFCR Sanfilippo C Enzyme, fib
<input type="checkbox"/>	ZFUCW Alpha-Fucosidase, wbc	Metachromatic Leukodystrophy Disease (MLD)		Sanfilippo Disease, Type D	
Fabry Disease		<input type="checkbox"/>	ZASAR Aryl Sulfatase A, fib	<input type="checkbox"/>	ZSFDR Sanfilippo D Enzyme, fib
<input type="checkbox"/>	ZAGLR Alpha-Galactosidase, fib	<input type="checkbox"/>	ZASAW Aryl Sulfatase A, wbc	Schindler Disease	
<input type="checkbox"/>	ZAGLW Alpha-Galactosidase, wbc	Morquio Disease, Type A		<input type="checkbox"/>	ZANGR Alpha-NAcgalactosaminidase, fib
Galactosialidosis		<input type="checkbox"/>	ZMQAR GalNAc Sulf Sulfatase, fib	<input type="checkbox"/>	ZANGW Alpha-NAcgalactosaminidase, wbc
<input type="checkbox"/>	ZANRR Alpha-Neuraminidase, fib	<input type="checkbox"/>	ZMQAW GalNAc Sulf Sulfatase, wbc	Sialidosis	
<input type="checkbox"/>	ZBGLR Beta-Galactosidase, fib	Morquio Disease, Type B		<input type="checkbox"/>	ZANRR Alpha-Neuraminidase, fib
<input type="checkbox"/>	ZBGLW Beta-Galactosidase, wbc	<input type="checkbox"/>	ZBGLR Beta-Galactosidase, fib	Sly Disease	
Gaucher Disease (Glucocerebrosidase)		<input type="checkbox"/>	ZBGLW Beta-Galactosidase, wbc	<input type="checkbox"/>	ZGLRR Beta-Glucuronidase, fib
<input type="checkbox"/>	ZBGCR Beta-Glucosidase, synthetic, fib	Niemann-Pick A and B Variants		<input type="checkbox"/>	ZGLRW Beta-Glucuronidase, wbc
<input type="checkbox"/>	ZBGCW Beta-Glucosidase, synthetic, wbc	<input type="checkbox"/>	ZSPMR Sphingomyelinase, fib	Tay-Sachs	
GM1 Gangliosidosis		Pompe Disease		<input type="checkbox"/>	ZHEXB Beta Hexosaminidase, s
<input type="checkbox"/>	ZBGLR Beta-Galactosidase, fib	<input type="checkbox"/>	ZAGCR Alpha-Glucosidase, fib	<input type="checkbox"/>	ZHEXR Beta Hexosaminidase, fib
<input type="checkbox"/>	ZBGLW Beta-Galactosidase, wbc	Sandhoff Disease		<input type="checkbox"/>	ZHEXW Beta Hexosaminidase, wbc
Hunter Disease		<input type="checkbox"/>	ZHEXB Beta Hexosaminidase, s	Wolman Disease and variants	
<input type="checkbox"/>	ZIDSB Iduronate Sulfatase, p, s	<input type="checkbox"/>	ZHEXR Beta Hexosaminidase, fib	<input type="checkbox"/>	ZLIPR Acid Lipase, fib
Hurler Disease		<input type="checkbox"/>	ZHEXW Beta Hexosaminidase, wbc	<input type="checkbox"/>	ZLIPW Acid Lipase, wbc
<input type="checkbox"/>	ZIDOR Alpha-Iduronidase, fib				
<input type="checkbox"/>	ZIDOW Alpha-Iduronidase, wbc				

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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ANALYTES

Referred-in Client 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: Interim 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: _____