

Referred-in Client Requisition

For Canada Only
 Health Card #: _____
 Issuing Province: _____
 Version: _____

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

Send-Out Instructions

Send this sample directly to SickKids. **DO NOT** send via third parties. This sample is requested in follow up to a positive newborn screening result.

SPECIMEN COLLECTION INFORMATION

Date (YYYY-MM-DD)	Time (HH:MM)
_____	_____

Newborn Screening Requisition Required Information (Will be pre-filled by NBS Team)

Name:	Ordering Physician: [To be filled by NBS Team] _____
HCN:	CC Results: [Referring Lab Institution or Fax #] _____
SickKids MRN #:	SickKids Newborn Screening Contact 416-813-7410 _____

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

All tests ordered below are to be prioritized as STAT
 Please refer to the Sickkids test catalogue [website](#) for collection instructions

PLASMA or SERUM (Frozen sent on dry ice)	WHOLE BLOOD (Store and ship at 4°C within 24hrs)	URINE (Frozen sent on dry ice)
Homocysteine Green Top (LiHep) or Red Top	Galactosemia Screen * Green Top (LiHep) ONLY	Urine Organic Acids
Total and Free Carnitine Green Top (LiHep) or Red Top	TBNK Immunophenotyping Purple Top (EDTA) Only	Urine Amino Acids
Amino Acids Green Top (LiHep) or Red Top	Recent Thymic Emigrants Purple Top (EDTA) Only	Urine Succinylacetone
Biotinidase* Plasma Green Top (LiHep) ONLY		Urine total and free Carnitine
Homocysteine Green Top (LiHep) or Red Top		Urine Creatine Panel
Methylmalonic acid in blood (MMA) Green Top (LiHep) or Red Top		
Acylcarnitine Green Top (LiHep) or Red Top		
17-OH Progesterone Green Top (LiHep) or Red Top		
Renin* Purple Top (EDTA) Only		

Additional Testing

Lab Comments

Referred-in Client Requisition

For Canada Only
 Health Card #: _____ Version: _____
 Issuing Province: _____

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

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): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____

Address: _____ Apt. #: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

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): _____

Additional Contact Information

Patient's phone # with area code:

_____ - or - _____

Guardian's phone # with area code:
