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

BIOCHEMISTRY

Referred-in Client Requisition

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:

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 #:

STORAGE / TRANSPORTATION	Send specimens frozen unless otherwise specified.

	Test Name	Specimen Requirements	
☐	**11-Deoxycortisol, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**17-Hydroxy Progesterone, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**21-HydroxyProgesterone, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**Alpha-fetoprotein (AFP), Blood**	150 uL	Serum
☐	**Androstenedione, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**Anti-TPO, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐	**Breath Hydrogen**	20 cc	Expired Air ***(Contact lab before sending)***
☐	**Carotene, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**Chylomicrons in Fluids - ChyloThorax Investigation**	300 uL	Fluid samples (e.g., pleural, peritoneal, chest drainage) ***(Send cold with ice packs)***
☐	**Corticosterone, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**Cortisol, Blood**	400 uL	Serum, Plasma (Lithium Heparin)
☐	**DHEA-S, Blood**	1mL	Serum, Plasma (Lithium Heparin)
☐	**Estradiol (Sensitive), Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐	**Fecal Elastase, Stool**	10 g	Random stool
☐	**Fecal Fat, Stool**	100 g	Feces ***(Contact lab before sending)***
☐	**Ferritin, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐	**Folate, Serum and RBC**	150 uL	Serum, Protect from light, EDTA for RBC Folate
☐	**Free Fatty Acid, Blood**	150 uL	Serum
☐	**FSH, Blood**	150 uL	Serum, Plasma (Lithium Heparin)

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☐ **Growth Hormone, Blood**	250 uL	Serum
☐ **hCG (Total B-hCG), Blood (Pregnancy)**	150 uL	Serum
☐ **hCG (Total B-hCG), Blood (Tumor marker)**	150 uL	Serum
☐ **Homocysteine, Blood**	300 uL	Serum, Plasma (Lithium Heparin / K-EDTA)
☐ **Homovanillic Acid (HVA), Urine**	20 mL	Urine
☐ **IGF-1, Blood**	200 uL	Serum
☐ **Insulin, Blood**	250 uL	Serum, Plasma (Sodium / Lithium Heparin)
☐ **Intralipid, Blood**	200 uL	Serum ***(Do not freeze. Send in ice packs)***
☐ **LH, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐ **Osmolarity, Blood**	60 uL	Serum, Plasma (Lithium Heparin)
☐ **Pancreatic Amylase, blood**	200 uL	Serum, Plasma (Lithium Heparin)
☐ **Plasma Haemoglobin, Blood**	1200 uL	Plasma (Lithium Heparin)
☐ **Progesterone, Blood**	500 uL	Serum, Plasma (Lithium Heparin)
☐ **Prolactin, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐ **PTH - Intact, Blood**	300 uL	Serum
☐ **Renin, Direct, Blood**	1 mL	EDTA plasma
☐ **Soluble Transferrin Receptor**	250 uL	Serum, Plasma (Lithium Heparin)
☐ **Sweat Chloride**	40 uL	Sweat
☐ **T3 - Total, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐ **T4 - Free, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐ **Testosterone, Blood**	300 uL	Serum
☐ **TSH, Blood**	300 uL	Serum, Plasma (Sodium / Lithium Heparin)
☐ **Vanillylmandelic Acid (VMA), Urine**	20 mL	Urine
☐ **Vitamin A, Blood**	300 uL	Serum, Plasma (Lithium Heparin)
☐ **Vitamin B12, Blood**	150 uL	Serum, Plasma (Lithium Heparin)
☐ **Vitamin D2 and D3, Blood**	300 uL	Serum, Plasma (Lithium Heparin)
☐ **Vitamin E, Blood**	300 uL	Serum, Plasma (Lithium Heparin)

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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: ____________________

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:
____