



# NL Health Services

## Rheumatology Outpatient Requisition Laboratories St. John's

Ordering Provider's Name: _____	<b>Clinic Stamp:</b> (include fax, provider and mnemonics)	
Clinic Name: _____		
Mailing Address: _____		
City: _____		
Province/Territory: _____	Postal Code: _____	
Telephone: _____	Fax: _____	
Signature: _____	Date: _____	
Ordering Provider's Meditech Mnemonic: _____		
EMR Clinic Mnemonic: _____		
COPY TO PROVIDER		

### Refer to Policy MED-LAB-050 Laboratory Requisitions

Testing may be delayed or not performed if the requisition is illegible, information is missing, or the specimen is mislabeled  
**BRING YOUR MCP CARD WHEN YOU GO FOR YOUR LAB TEST**

If fasting is required – do not eat or drink anything (except water or medications) for the time period indicated

### DIAGNOSIS/RELEVANT HISTORY

Frequency of Testing (For Repeat Testing) \_\_\_\_\_ Date of collection (YYYY/MON/DD): \_\_\_\_\_ Time (HH:MM): \_\_\_\_\_

<b>HEMATOLOGY (Collect Lavender Tube)</b>		<b>OTHER (Collect SST Tube – Gold with red dot, ** See exceptions)</b>
<input type="checkbox"/> CBC	CBC, includes automated differential	<input type="checkbox"/> ANAACAP Anti-Nuclear Antibody (ANA)/Anti-Nuclear
<input type="checkbox"/> ESR	Sedimentation Rate	<input type="checkbox"/> CYCPAB Cytoplasmic Antibody (ACA) Panel
<b>COAGULATION (Collect in Light Blue Tube)</b>		<input type="checkbox"/> CERUL Ceruloplasmin
<input type="checkbox"/> PTI	PT-INR	<input type="checkbox"/> COLAGGP Cold Agglutinins **Collect Red Tube
<input type="checkbox"/> PTPTT	PTI-PTT	<input type="checkbox"/> CRPHS C-Reactive Protein; High Sens
<b>CHEMISTRY</b> Note: If there is fasting required, collect SST Tube-Gold with red dot		<input type="checkbox"/> CRYOG Cryoglobulins **Collect Red Tube
<input type="checkbox"/> ALBUM	Albumin	<input type="checkbox"/> SACABP Extractable Nuclear Ag
<input type="checkbox"/> CALCI	Calcium & Albumin	<input type="checkbox"/> IMMUNP Immunoglobulins
<input type="checkbox"/> COMC3	Complement 3	<input type="checkbox"/> PTH Parathyroid Hormone
<input type="checkbox"/> COMC4	Complement 4	<input type="checkbox"/> PROELP Protein Electrophoresis Panel
<input type="checkbox"/> CREKI	Creatinine Phosphokinase	<input type="checkbox"/> RHEFA Rheumatoid Factor
<input type="checkbox"/> DNADSAB	DNA Double Strand Antibody	<input type="checkbox"/> FERRI Serum Ferritin
<input type="checkbox"/> LBC	Electrolytes, Urea & Creatinine (eGFR)	<input type="checkbox"/> STROAB Streptolysin O Ab
<input type="checkbox"/> GGT	Gamma Glutamyl Transferase	<input type="checkbox"/> TSH Thyroid Stimulating Hormone
<input type="checkbox"/> GLUFA	Glucose (Fasting – 8 hrs)	<input type="checkbox"/> VITB12 Vitamin B12
<input type="checkbox"/> HEPFUP	Hepatic Function Panel (ALP, ALT)	
<input type="checkbox"/> CALIOG	Ionized Calcium	
<input type="checkbox"/> IRIBCP	Iron, IBC Panel	
<input type="checkbox"/> LD	Lactate Dehydrogenase	
<input type="checkbox"/> PHOSP	Phosphate	
<input type="checkbox"/> GLUCO	Random Glucose (No fasting)	
<input type="checkbox"/> LIPIDP	Serum Lipid Profile (Fasting -12 hrs) <input type="checkbox"/> Non-fasting	
<input type="checkbox"/> PROTE	Total Protein	
<input type="checkbox"/> URATE	Uric Acid	
<b>SEROLOGY</b>		
<input type="checkbox"/> HBSAB	Hepatitis B Surface Antigen	
<input type="checkbox"/> HCVABL	Hepatitis C Antibodies	
<input type="checkbox"/> PARB19ABG	Parvo Virus 19 – IgG	
<input type="checkbox"/> PARB19ABP	Parvovirus B19 Ab Panel	
<b>URINE TESTING (Sterile Urine Container)</b>		
<input type="checkbox"/> URINCU	Urine Culture (Midstream Urine)	
<input type="checkbox"/> URINAP	Urinalysis Panel	
<b>ADDITIONAL TEST(S) REQUIRED – PRINT LEGIBLY</b>		
<input type="checkbox"/>		