PHOL Use Only: **Date Received: _____** **PHOL No. _____**

Public Health Ontario | Santé publique Ontario

HEPATITIS C (HCV) RNA TEST REQUISITION

Minimum 2.5 mL serum or EDTA plasma removed from clot within 6 hours of collection and submitted frozen or minimum of 4 appropriately collected Dried Blood Spots (DBS) to PHOL.

Submitter

Courier Code

Provide Return Address:

Name
Address
City & Province
Postal Code

Clinician Initial / Surname and OHIP / CPSO Number

Tel:_____ Fax:_____

cc Doctor Information

Name:_____ Tel:_____
Lab/Clinic Name:_____ Fax:_____
CPSO #:_____
Address:_____ Postal Code:_____

Patient Information

Health No.	Sex	Date of Birth: yyyy / mm / dd
Medical Record No.		
Patient's Last Name *(per OHIP card)*		First Name *(per OHIP card)*
Patient Address		
Postal Code		Patient Phone No.
Submitter Lab No.		

Specimen Details

Date Collected: yyyy / mm / dd

Type of Specimen:
- ☐ Serum
- ☐ EDTA Plasma
- ☐ DBS

☐ **Diagnostic:** To be used only in patients who are HIV positive, immunocompromised, infant of HCV positive mother, patient with anti-HCV indeterminate result and 8-10 weeks post exposure. Please specify under " Other relevant and clinical information" below the clinical reason this test is being requested for diagnosis of HCV infection.

☐ **Pre-Treatment:** Genotyping and Baseline viral load

☐ **On Treatment:**
☐4 weeks ☐ 8 weeks ☐ 12 weeks ☐Other Specify # of weeks ____

☐ **Post Treatment:** _____ weeks/months
(2 samples less than the detection limit (<15 IU/mL) and 6 months apart are required to confirm successful treatment. No follow up required unless there is a new exposure).

☐ **HCV DRUG RESISTANCE TESTING (Criteria for Eligibility: HCV VL ≥ 10,000 (1 x 10E+4) IU/mL)**

☐Test on previously tested HCV VL/GENO sample. PHL Lab no.: _____
☐Test on new sample. (Submit 2.5 mL frozen serum or EDTA plasma)

Other relevant and clinical information

_____

_____

_____

This form is available at: http://www.publichealthontario.ca/Requisitions

The personal health information is collected under the authority of the Personal Health Information Protection Act, (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHOL Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567 (03/2016)

PHOL Use Only: **Date Received: _____** **PHOL No. _____**

Public Health Ontario | Santé publique Ontario

HEPATITIS B (HBV) DNA TEST REQUISITION

Minimum volume 2.5 mL serum or EDTA plasma removed from clot within 6 hours of collection and submitted frozen to PHOL.

Submitter

Courier Code

Provide Return Address:

Name
Address
City & Province
Postal Code

Clinician Initial / Surname and OHIP / CPSO Number

Tel:_____ Fax:_____

cc Doctor Information

Name:_____ Tel:_____
Lab/Clinic Name:_____ Fax:_____
CPSO #:_____
Address:_____ Postal Code:_____

Patient Information

Health No.	Sex	Date of Birth: yyyy / mm / dd
Medical Record No.		
Patient's Last Name *(per OHIP card)*		First Name *(per OHIP card)*
Patient Address		
Postal Code		Patient Phone No.
Submitter Lab No.		

Specimen Details

Date Collected: yyyy / mm / dd

Type of Specimen:

- ☐ Serum
- ☐ EDTA Plasma

☐ **Pre-Treatment**

☐ **On-Treatment:** _____ months (routine monitoring)

☐ **Query Viral Breakthrough:**
(Provide viral load and dates for last two treatment samples)

1. _____ (Viral Load) _____ (Date Reported)

2. _____ (Viral Load) _____ (Date Reported)

☐ **Post-Treatment:**_____ weeks/months

Other relevant and clinical information

_____

_____

_____

This form is available at: http://www.publichealthontario.ca/Requisitions

The personal health information is collected under the authority of the Personal Health Information Protection Act, (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHOL Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567 (12/2012)