Public Health Ontario | Santé publique Ontario

PUBLIC HEALTH ONTARIO LABORATORY (PHOL) HEPATITIS PCR REQUISITION

HEPATITIS C RNA AND/OR HEPATITIS B DNA VIRAL LOAD

1. For HCV RNA, complete **page 2** of this form and submit minimum 2.5 ml frozen serum or EDTA plasma or if patient qualifies, 4 appropriately collected and submitted Dried Blood Spots (DBS)

2. For HBV DNA, complete **page 3** of this form and submit minimum 2.5 ml frozen serum or EDTA plasma

3. For both HCV RNA and HBV DNA, complete **pages 2 and 3** of this form and submit with minimum **5.0 ml** frozen serum or EDTA plasma

Ensure that the following has been completed before submitting to PHOL:

☐ 2.5 ml frozen serum or EDTA plasma is provided *(if both HCV and HBV DNA requested, submit 5.0 ml frozen serum or EDTA plasma)*

☐ Sender and Patient information is complete and contains:

- Patient name, HIN, Date of Birth, and Address
- Ordering physician/laboratory name, and complete mailing address

☐ Specimen is labeled with 2 unique identifiers that (must) match the Requisition

For further information:

1. Test information sheets and this form are available at www.publichealthontario.ca/testdirectory
2. Public Health Ontario Laboratory Customer Service Centre 416-235-6556 or toll free 1-877-604-4567

Ontario Agency for Health Protection and Promotion / Agence de protection et de promotion de la santé

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

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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. _____**

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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

_____

_____

_____

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