SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

Division of Biochemistry
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-5431

Patient Name:
Date of Birth (DD/MM/YYYY):
Sex Assigned at Birth: ○ *Male* ○ *Female* ○ *Unassigned*
Legal Sex (if different): ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Gender Identity: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Parent's Name:
Address:

For Canada Only
Health Card #:
Issuing Province:

Version

IMMUNOLOGY

Referred-In Client Requisition

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

REFERRING LABORATORY/ INSTITUTION	
Name:	**Address:**
Telephone:	**Fax:**
Ordering Physician:	

SPECIMEN INFORMATION		
Collection Date: _____ (DD/MM/YYYY)	**Collection Time:** _____ (hh:mm)	**Referring Specimen/Reference #:** _____
STORAGE/TRANSPORTATION	**Send specimens frozen unless otherwise specified**	

CLINICAL INFORMATION/DIAGNOSIS (Please provide this information to support use of optimal lab protocol for testing)

IMMUNOSUPPRESSIVE THERAPIES GIVEN (Please provide this information to support result interpretation)

TEST(S) REQUESTED		**SPECIMEN REQUIREMENTS**	
Antibody assays			
Indirect immunofluorescence assays			
☐	Anti-dsDNA IgG, *Crithidia luciliae*	0.3 mL for 1 test or 0.6 mL min for several tests	Serum
☐	Anti-Endomysial antibody (EMA), IgA		
☐	Anti-Glomerular Basement Membrane (AGBM), IgG		
☐	Anti-Liver Kidney Microsomal Antibody (ALKM), IgG		
☐	Anti-Neutrophil cytoplasmic antibody (ANCA), IgG		
☐	Anti-nuclear Antibody (ANA), HEp-2 IgG		
☐	Anti-Parietal Cell antibody (APC), IgG		
☐	Anti-Smooth Muscle Antibody (ASMA), IgG		
☐	Anti-tissue Transglutaminase (tTG), IgA		

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TEST(S) REQUESTED		SPECIMEN REQUIREMENTS
Immunoassays		
☐ Anti-Cardiolipin, IgG	0.3 mL for 1 test or 0.6 mL min for several tests	Serum
☐ Anti-dsDNA, IgG		
☐ Anti-La, IgG		
☐ Anti-Myeloperoxidase (MPO), IgG		
☐ Anti-Proteinase 3 (PR3), IgG		
☐ Anti-RNP, IgG		
☐ Anti-Ro52, IgG		
☐ Anti-Ro60, IgG		
☐ Anti-Sm, IgG		
☐ Anti-Pneumococcal IgG ☐ Pre-vaccination ☐ Post-vaccination	0.25 mL	Serum (Red top tube) – not shared with other immunoassays
Inflammatory markers		
☐ Soluble IL-2 Receptor (CD25)	2 aliquots of 0.3mL each	EDTA plasma
☐ **Cytokine Panel 1**		
☐ Interleukin 1 Beta (IL-1β)	2 aliquots of 0.3 mL each for any combination of IL-10, IL-18, IL-1 β and IL-6	EDTA plasma: special centrifugation requirements
☐ Interleukin 6 (IL-6)		
☐ Interleukin 10 (IL-10)		
☐ Interleukin 18 (IL-18)		
☐ **Cytokine Panel 2**		
☐ CD163	2 aliquots of 0.3 mL each for any combination of TNF-α, CXCL9, IFN- γ, and CD163	EDTA plasma: special centrifugation requirements
☐ CXCL9/MIG		
☐ IFN-Gamma (IFN-γ)		
☐ TNF-alpha (TNF-α)		

Laboratory Use: _____-_____ Date/time received (yyyy/mm/dd – hh:mm) SickKids Spec #

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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: Interim 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: _____

CVV#- 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:

_____