SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

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

Tel: 416-813-5906
Fax: 416-813-5341

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 (if applicable):
Address:

For Canada Only
Health Card #:
Issuing Province:

Version

DRUG FACILITATED SEXUAL ASSAULT

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.

☐ **Priority** ☐ **STAT** ☐ **Routine**

Referring Laboratory/Institution	Phone: Fax:
Name	Email:
Address	Ordering Physician

CLINICAL INFORMATION

Drug Facilitated Sexual Assault	
Suspected Drugs, Mode and Time of Intake:	Medication Given or Prescribed:

SPECIMEN AND REQUEST INFORMATION

❑ **BLOOD** (10 mL clotted required)	❑ **URINE** (10 mL required)
Collection date and time	Collection date and time
_____-_____-_____ _____:_____h	_____-_____-_____ _____:_____h
(DD-MM-YYYY) (hh:mm)	(DD-MM-YYYY) (hh:mm)
Your Specimen #	Your Specimen #
❑ Blood Panel	**❑ Urine**
• Broad Spectrum Drug Screen • Barbiturate/Sedative Screen • Benzodiazepine Screen/Identification *(included in Broad Spectrum Drug Screen)* • Volatile Screen *(Ethanol, Methanol, Isopropanol, Acetone)* • GHB	• Broad Spectrum Drug Screen • Barbiturate Screen • Benzodiazepine Screen/Identification *(included in Broad Spectrum Drug Screen)* • THC Screen • Volatile Screen *(Ethanol, Methanol, Isopropanol, Acetone)* • GHB

❑ Blood & Urine Panel

- Broad Spectrum Drug Screen – urine
- Barbiturate Screen - urine
- Benzodiazepine Screen/Identification - urine *(included in Broad Spectrum Drug Screen)*
- THC - urine
- GHB - urine
- Volatile Screen *(Ethanol, Methanol, Isopropanol, Acetone)* – blood
- Barbiturate/Sedative Screen – blood
- Benzodiazepine Screen/Identification – blood

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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.

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:_____

CVC#- 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:

_____