THE HOSPITAL FOR SICK CHILDREN

Paediatric Laboratory Medicine

METABOLIC DISEASES LABORATORY

555 University Avenue
Room 3333, Black
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-6599

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:

SPECIMEN COLLECTION INFORMATION	
Date (YYYY-MM-DD)	**Time** (HH:MM)

ANALYTES

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 Physician / Institution	
Name:	**Address**

Clinical Information/Diagnostic Indications (essential for adequate evaluation of test results)

Special Diet: ☐ No ☐ Yes (medium-chain triglycerides ☐ No ☐ Yes)
Exclusion of specific diagnosis: ☐ No ☐ Yes - Details: ____________________
Follow-up/Repeat changes: ☐ No ☐ Yes - Details: ____________________

PLEASE NOTE: The test codes below are SAMPLE TYPE SPECIFIC — **p** = plasma; **s** = serum; **u** = urine

Screens

	Code	Test
Blood		
☐	YGALS	Galactosemia Screen, whole blood (GAL-1-PUT screen)**
Urine		
☐	ZGCLU	Glycolipids TLC, u
☐	ZMPSU	Mucopolysaccharides Screen, u
☐	ZMPTU	Mucopolysaccharides TLC, u *(available only if screen is positive otherwise, please specify reason:* ______ ______ ______ *)*
☐	ZOGOU	Oligosaccharides, u
☐	ZOGSAU	Sialic Acid TLC, u
☐	YSIDU	Sugar Identification TLC, u

**For patients > 18 years of age, please provide clinical indications

Analytes Test Menu

	Code	Test
Blood		
☐	YQACY	Acylcarnitine, quantitative, p, s
☐	YQAAA	Amino acids, quantitative, p, s
☐	YBHB	Beta-Hydroxybutyrate, p, s
☐	YBTIN	Biotinidase, s, p
☐	YFCRN YCRN	Carnitine Free & Total, s, p
☐	YCDGT	CDG Transferrin, s
☐	YFFA	Free Fatty Acid, s
☐	HMC	Homocysteine, p, s
☐	YMMA	Methylmalonic Acid, p, s
☐	YPOXA	Oxalic acid, p
☐	YPYR	Pyruvate, s
Blood Spot (filter paper)		
☐	YMSUDB	Valine, Leucine, Alloisoleucine, IsoLeucine, blood spot
☐	YPHEB YTYRB	Phenylalanine and Tyrosine, blood spot

	Code	Test
CSF		
☐	YQAAFF	Amino acids, quantitative, csf
☐	YBHBF	Beta-Hydroxybutyrate, csf
☐	YPYRF	Pyruvate, csf
Urine		
☐	YQAAUU	Amino acids, quantitative, u
☐	YFCRNU YCRNU	Carnitine Free & Total, u
☐	YCDPU	Creatine/Guanidinoacetate panel, u
☐	YHYOXU	Hyperoxaluria panel, u
☐	YORGU	Organic Acid, u
☐	YOROU	Orotic Acid, u
☐	YSAU	Succinylacetone, u
☐	YSULU	Sulfatides, u
☐	YSCU	Sulfocysteine, u

For alternative sample types or diseases not listed above, please contact the Customer Service at **416-813-7200** and request a consult with a Metabolic Diseases' staff member.

Disease Name:____________________ **Alternative Sample Type:**____________________

THE HOSPITAL FOR SICK CHILDREN

Paediatric Laboratory Medicine

METABOLIC DISEASES LABORATORY

555 University Avenue
Room 3333, Black
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-6599

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:

ANALYTES

Referred-in Client Requisition

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' Genome Diagnostics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

- **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 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): __________

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.

- Only eligible verified IFHP will be accepted.
- Eligible patients are issued one of two possible IFHP eligibility documents: a Refugee Protection Claimant Document (with photo) (RPCD) or an Interim Federal Health Program Certificate (IFHC).
- All documentation must be current with acceptable client information, client ID (UCI #), expiry date, IFHP Effective date, IFHP expiry date, signature and photo.
- Specimens without proper documentation will NOT be accepted.

For additional details on the IFHP program, visit www.cic.gc.ca/ifhp.

UCI# ______________________ ICD code *(lab use only)*: ______________________

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: ______________________

Note: For clinical use only. Results not generated in a forensically accredited laboratory.