SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

METABOLIC DISEASES LABORATORY
555 University Avenue
Room 3333, Atrium
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:
Address:

For Canada Only
Health Card #:
Issuing Province:
Version:

METABOLIC DISEASES LYSOSOMAL ENZYMES

Referred-in Client Requisition

SPECIMEN COLLECTION INFORMATION

Date (YYY-MM-DD) _____ Time (HH:MM) _____

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)

PLEASE NOTE: The test codes below are SAMPLE TYPE SPECIFIC. **fib** fibroblasts; **p** plasma; **s** serum; **wbc** leukocytes

LYSOSOMAL ENZYME ANALYSIS TEST MENU

Alpha-Mannosidosis		
☐	ZAMNR	Alpha-Mannosidase, fib
☐	ZAMNW	Alpha-Mannosidase, wbc
Beta-mannosidosis		
☐	ZBMNR	Beta-Mannosidase, fib
☐	ZBMNW	Beta-Mannosidase, wbc
Fucosidosis		
☐	ZFUCR	Alpha-Fucosidase, fib
☐	ZFUCW	Alpha-Fucosidase, wbc
Fabry Disease		
☐	ZAGLR	Alpha-Galactosidase, fib
☐	ZAGLW	Alpha-Galactosidase, wbc
☐	ZAGLB	Alpha-Galactosidase, s, p
Galactosialidosis		
☐	ZANRR	Neuraminidase, fib
☐	ZBGLR	Beta-Galactosidase, fib
☐	ZBGLW	Beta-Galactosidase, wbc
Gaucher Disease (Glucocerebrosidase)		
☐	ZBGCR	Beta-Glucosidase,synthetic, fib
☐	ZBGCW	Beta-Glucosidase,synthetic, wbc
GM1 Gangliosidosis		
☐	ZBGLR	Beta-Galactosidase, fib
☐	ZBGLW	Beta-Galactosidase, wbc
Hunter Disease		
☐	ZIDSB	Iduronate 2-Sulfatase, s, p
Hurler Disease		
☐	ZIDOR	Alpha-Iduronidase, fib
☐	ZIDOW	Alpha-Iduronidase, wbc

I-CELL Disease Lysosomal Hydrolases		
☐	ZHEXB	Beta-Hexosaminidase, s
Krabbe Leukodystrophy		
☐	ZGCRR	Galactocerebrosidase, fib
☐	ZGCRW	Galactocerebrosidase, wbc
Maroteaux-Lamy Disease		
☐	ZASBR	ArylSulfatase B, fib
☐	ZASBW	ArylSulfatase B, wbc
Metachromatic Leukodystrophy Disease (MLD)		
☐	ZASAR	ArylSulfatase A, fib
☐	ZASAW	ArylSulfatase A, wbc
Morquio Disease, Type A		
☐	ZMQAR	GalNAc Sulf Sulfatase, fib
☐	ZMQAW	GalNAc Sulf Sulfatase, wbc
Morquio Disease, Type B		
☐	ZBGLR	Beta-Galactosidase, fib
☐	ZBGLW	Beta-Galactosidase, wbc
Niemann-Pick A and B Variants		
☐	ZSPMR	Sphingomyelinase, fib
Pompe Disease		
☐	ZAGCR	Alpha-Glucosidase, fib
Sandhoff Disease		
☐	ZHEXB	Beta-Hexosaminidase, s
☐	ZHEXR	Beta-Hexosaminidase, fib
☐	ZHEXW	Beta-Hexosaminidase, wbc

Sanfilippo Disease, Type A		
☐	ZSFAR	Sanfilippo A Enzyme, fib
Sanfilippo Disease, Type B		
☐	ZSFBB	Sanfilippo B Enzyme, s, p
☐	ZSFBR	Sanfilippo B Enzyme, fib
☐	ZSFBW	Sanfilippo B Enzyme, wbc
Sanfilippo Disease, Type C		
☐	ZSFCR	Sanfilippo C Enzyme, fib
San ilippo Disease, Type D		
☐	ZSFDR	Sanfilippo D Enzyme, fib
Schindler Disease		
☐	ZANGR	Alpha-NAcgalactosaminidase, fib
☐	ZANGW	Alpha-NAcgalactosaminidase, wbc
Sialidosis		
☐	ZANRR	Neuraminidase, fib
Sly Disease		
☐	ZGLRR	Beta-Glucuronidase, fib
☐	ZGLRW	Beta-Glucuronidase, wbc
Tay-Sachs		
☐	ZHEXB	Beta-Hexosaminidase, s
☐	ZHEXR	Beta-Hexosaminidase, fib
☐	ZHEXW	Beta-Hexosaminidase, wbc
Wolman Disease and variants		
☐	ZLIPR	Lysosomal Acid Lipase, fib
☐	ZLIPW	Lysosomal Acid Lipase, wbc

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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' 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: 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: _____

CVS#- 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:

_____