SickKids
THE HOSPITAL FOR SICK CHILDREN

MICROBIOLOGY LABORATORY
555 University Avenue
Room 3676, Atrium
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-6000
Fax: 416-813-5993

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

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

QUANTIFERON TB (QFT)

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.

Testing Requested by Public Health Unit:

☐ TPH Pilot - iPHIS ID: _____

Referring Physician

Hospital *(specify)*: _____

Doctor's Office: _____

Referring Laboratory: _____

Referring Lab Accession #: _____

Mailing Address:

Telephone Number: _____

Fax Number: _____

Specimen Collection Information

Date (DD/MM/YYYY): _____ **Time** (HH:MM): _____ **Collected By:** _____

Shipping Instructions

All specimens that DO NOT MEET the transport requirements will be **REJECTED**.

Optimal Collection Time / Storage / Transportation / Receipt of Samples

Blood Collection Tube: 6mL Lithium - heparin tube (green top/white label).

- Tubes should be between room temperature (17–25°C) at the time of blood filling.
- Only a Lithium - heparin anticoagulant is acceptable.

Blood collection: Collect a minimum volume of 5 mL of blood into a **single** Lithium - heparin tube.

- Gently mix by inverting several times to dissolve the heparin.
- Blood must first be held at room temperature (17–25°C) for a minimum of 15 minutes and a maximum of 3 hours before being placed in the refrigerator (2–8°C).
- Specimen may be held in the refrigerator for a further 16 to 48 hours before shipping.

Shipping to SickKids Microbiology:

- Ship on ice packs.
- Total time from collection to receipt in SickKids Microbiology laboratory **cannot** exceed 50 hours.

Specimen Shipping & Receipt / Handling at SickKids:

- *Specimens should be shipped Monday to Friday and received at SickKids by 5pm.*
  - *Deliver to: Microbiology Laboratory, room 3676, 3rd floor Atrium.*
  - *Specimens will be transferred to QFT – Plus Blood Collection Tubes on receipt.*
- *After hours: Deliver specimens to the Rapid Response Laboratory room 3642.*

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Risk Factors for TB Infection

Birthplace: Child Mother Father

Last travel outside Canada: Date (MM/YYYY)_____ Country _____

Prior BCG: ☐ Yes, Date (DD/MM/YYYY)_____ ☐ No ☐ Unknown

Indication

1) Known contact of TB that is:

☐ Fully Sensitive ☐ Sensitivity Unknown ☐ Multi-Drug Resistant (MDR) ☐ Resistant to one agent _____

Break in Contact from Index Case was (DD/MM/YYYY) _____

2) Suspected of having active TB disease ○ No ○ Yes

3) Prior Treatment for TB disease ○ No ○ Yes Date (MM/YYYY)_____

4) Immunocompromised ○ No ○ Yes Condition _____

5) Pre Biologic ○ No ○ Yes Underlying Condition _____

6) Other _____

Tuberculosis Skin Test (TST) Result

Skin Test Planted (DD/MM/YYYY)	Skin Test Read (DD/MM/YYYY)	Result (mm of induration)
1st test:	1st test:	1st test:
2nd test:	2nd test:	2nd test:

QFT Specimen Information

Date/Time Received	Aliquot into QFT tubes	Incubated:
Centrifuged	Test Date	

Internal Use Only

Microbiologist Review_____

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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: 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): _____