SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

TOXICOLOGY&THERAPEUTIC DRUG MONITORING SERVICE
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

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

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:

THERAPEUTIC DRUG MONITORING

Referred-in Requisition

Urgency ☐ **STAT** ☐ **Routine**

Referring Physician:
Referring Institution:
Address:
Phone Results to:
Tel #: **Fax #:**

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

Clinical Comments:

Collection Date (DD-MM-YYYY)

Collection Time (hh:mm)

Referring Specimen/Reference #:

ANTIBIOTICS	Specimen Requirements
Amikacin	0.5 mL, plasma or serum
☐ Amikacin Trough	
☐ Amikacin Peak	
☐ Amikacin Special	
Gentamicin	0.5 mL plasma
☐ Gentamicin Trough	
☐ Gentamicin Peak	
☐ Gentamicin Special	
Tobramycin	0.5 mL, plasma or serum
☐ Tobramycin Trough	
☐ Tobramycin Peak	
☐ Tobramycin Special	
Vancomycin	0.5 mL, plasma or serum
☐ Vancomycin Trough	
☐ Vancomycin Peak	
☐ Vancomycin Special	

ANTI-FUNGAL	Specimen Requirements
☐ Voriconazole	0.5 mL plasma

ONCOLOGY	Specimen Requirements
☐ Busulfan — Date & Time of Last Dose (DD/MM/YYYY) (hh:mm) _____ h	1.0 mL, plasma or serum
☐ Methotrexate — Date & Time of Last Dose (DD/MM/YYYY) (hh:mm) _____ h	0.5 mL, plasma or serum

ANTICONVULSANTS	Specimen Requirements
☐ Carbamazepine 10, 11-Epoxide	0.5 mL, plasma or serum
☐ Ethosuximide	0.5 mL, plasma or serum
☐ Lamotrigine	0.5 mL, serum
☐ Phenobarbital	0.5 mL, plasma or serum
☐ Phenytoin (Total)	0.5 mL, plasma or serum
☐ Phenytoin (Free)	1.0 mL, plasma or serum
☐ Primidone	0.5 mL, plasma or serum
☐ Valproic Acid (Total)	0.5 mL, plasma or serum
☐ Valproic Acid (Free)	1.0 mL, plasma or serum

IMMUNOSUPPRESSANTS	Specimen Requirements
☐ Azathioprine Metabolites/Thiopurine Metabolites (6-TG, 6-MMP)	5.0 mL, EDTA, whole blood
☐ Cyclosporine	0.5 mL, EDTA, whole blood
☐ Mycophenolic Acid (MPA)/ Mycophenolate Mofetil (MMF)	0.5 mL, EDTA, plasma
☐ Sirolimus (Rapamycin)	0.5 mL, EDTA, whole blood
☐ Tacrolimus (FK506)	0.5 mL, EDTA, whole blood

CARDIAC	Specimen Requirements
☐ Digoxin (Total)	0.5 mL, plasma or serum
☐ Digoxin (Free)	2.0 mL, plasma or serum

SEDATIVE	Specimen Requirements
☐ Pentobarbital	1.2 mL, plasma or serum

SickKids Lab #

LABORATORY USE ONLY

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BILLING FORM

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.**
  Invoices are sent upon completion of each test/service.

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: _____

CVC#- found on back of card (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Address: _____

_____ Apt. #: _____

City:_____ Prov/State: _____

Postal/Zip Code:_____ Country: _____

Additional Contact Information

Patient's/Guardian's phone # with area code: