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**PUBLIC HEALTH ONTARIO LABORATORY (PHOL) HEPATITIS PCR REQUISITION**

**HEPATITIS C RNA AND/OR HEPATITIS B DNA VIRAL LOAD**

1. For HCV RNA, complete **page 2** of this form and submit minimum 2.5 ml frozen serum or EDTA plasma or if patient qualifies, 4 appropriately collected and submitted Dried Blood Spots (DBS)
2. For HBV DNA, complete **page 3** of this form and submit minimum 2.5 ml frozen serum or EDTA plasma
3. For both HCV RNA and HBV DNA, complete **pages 2 and 3** of this form and submit with minimum **5.0 ml** frozen serum or EDTA plasma

**Ensure that the following has been completed before submitting to PHOL:**

- 2.5 ml frozen serum or EDTA plasma is provided (*if both HCV and HBV DNA requested, submit 5.0 ml frozen serum or EDTA plasma*)
- Sender and Patient information is complete and contains:
  - Patient name, HIN, Date of Birth, and Address
  - Ordering physician/laboratory name, and complete mailing address
- Specimen is labeled with 2 unique identifiers that (must) match the Requisition

**For further information:**

1. Test information sheets and this form are available at [www.publichealthontario.ca/testdirectory](http://www.publichealthontario.ca/testdirectory)
2. Public Health Ontario Laboratory Customer Service Centre 416-235-6556 or toll free 1-877-604-4567



### HEPATITIS C (HCV) RNA TEST REQUISITION

Minimum 2.5 mL serum or EDTA plasma removed from clot within 6 hours of collection and submitted frozen or minimum of 4 appropriately collected Dried Blood Spots (DBS) to PHOL.

<p><b>Submitter</b></p> <p>Courier Code: _____</p> <p>Provide Return Address:</p> <p>Name: _____          Address: _____          City &amp; Province: _____          Postal Code: _____</p> <p>Clinician Initial / Surname and OHIP / CPSO Number: _____</p> <p>Tel: _____ Fax: _____</p> <p><b>cc Doctor Information</b></p> <p>Name: _____ Tel: _____          Lab/Clinic Name: _____ Fax: _____          CPSO #: _____          Address: _____ Postal Code: _____</p>	<p><b>Patient Information</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Health No. _____</td> <td style="width: 10%;">Sex _____</td> <td style="width: 30%;">Date of Birth: _____ yyyy / mm / dd</td> </tr> <tr> <td>Medical Record No. _____</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Patient's Last Name (per OHIP card) _____</td> <td>First Name (per OHIP card) _____</td> </tr> <tr> <td colspan="3">Patient Address _____</td> </tr> <tr> <td>Postal Code _____</td> <td colspan="2">Patient Phone No. _____</td> </tr> <tr> <td colspan="3">Submitter Lab No. _____</td> </tr> </table> <p><b>Specimen Details</b></p> <p>Date Collected: _____ yyyy / mm / dd</p> <p><b>Type of Specimen:</b></p> <p><input type="checkbox"/> Serum  <input type="checkbox"/> EDTA Plasma  <input type="checkbox"/> DBS</p>	Health No. _____	Sex _____	Date of Birth: _____ yyyy / mm / dd	Medical Record No. _____			Patient's Last Name (per OHIP card) _____		First Name (per OHIP card) _____	Patient Address _____			Postal Code _____	Patient Phone No. _____		Submitter Lab No. _____		
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Postal Code _____	Patient Phone No. _____																		
Submitter Lab No. _____																			

- Diagnostic:** To be used only in patients who are HIV positive, immunocompromised, infant of HCV positive mother, patient with anti-HCV indeterminate result and 8-10 weeks post exposure. Please specify under "Other relevant and clinical information" below the clinical reason this test is being requested for diagnosis of HCV infection.
  
- Pre-Treatment:** Genotyping and Baseline viral load
  
- On Treatment:**  
 4 weeks     8 weeks     12 weeks     Other Specify # of weeks \_\_\_\_\_
  
- Post Treatment:** \_\_\_\_\_ weeks/months  
*(2 samples less than the detection limit (<15 IU/mL) and 6 months apart are required to confirm successful treatment. No follow up required unless there is a new exposure).*

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- HCV DRUG RESISTANCE TESTING (Criteria for Eligibility: HCV VL ≥ 10,000 (1 x 10E+4) IU/mL)**
    - Test on previously tested HCV VL/GENO sample. PHL Lab no.: \_\_\_\_\_
    - Test on new sample. (Submit 2.5 mL frozen serum or EDTA plasma)

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**Other relevant and clinical information**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This form is available at: <http://www.publichealthontario.ca/Requisitions>

The personal health information is collected under the authority of the Personal Health Information Protection Act, (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHOL Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567 (03/2016)



## HEPATITIS B (HBV) DNA TEST REQUISITION

Minimum volume 2.5 mL serum or EDTA plasma removed from clot within 6 hours of collection and submitted frozen to PHOL.

<p><b>Submitter</b></p> <p>Courier Code _____</p> <p>Provide Return Address:</p> <p>Name _____ Address _____ City &amp; Province _____ Postal Code _____</p> <p>Clinician Initial / Surname and OHIP / CPSO Number _____</p> <p>Tel: _____ Fax: _____</p> <p><b>cc Doctor Information</b></p> <p>Name: _____ Tel: _____ Lab/Clinic Name: _____ Fax: _____ CPSO #: _____ Address: _____ Postal Code: _____</p>	<p><b>Patient Information</b></p> <table border="1"> <tr> <td>Health No. _____</td> <td rowspan="2">Sex _____</td> <td>Date of Birth: _____ yyyy / mm / dd</td> </tr> <tr> <td>Medical Record No. _____</td> <td>_____</td> </tr> <tr> <td colspan="2">Patient's Last Name (per OHIP card) _____</td> <td>First Name (per OHIP card) _____</td> </tr> <tr> <td colspan="3">Patient Address _____</td> </tr> <tr> <td>Postal Code _____</td> <td colspan="2">Patient Phone No. _____</td> </tr> <tr> <td colspan="3">Submitter Lab No. _____</td> </tr> </table> <p><b>Specimen Details</b></p> <p>Date Collected: _____ yyyy / mm / dd</p> <p>Type of Specimen:</p> <p><input type="checkbox"/> Serum <input type="checkbox"/> EDTA Plasma</p>	Health No. _____	Sex _____	Date of Birth: _____ yyyy / mm / dd	Medical Record No. _____	_____	Patient's Last Name (per OHIP card) _____		First Name (per OHIP card) _____	Patient Address _____			Postal Code _____	Patient Phone No. _____		Submitter Lab No. _____		
Health No. _____	Sex _____	Date of Birth: _____ yyyy / mm / dd																
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Patient's Last Name (per OHIP card) _____		First Name (per OHIP card) _____																
Patient Address _____																		
Postal Code _____	Patient Phone No. _____																	
Submitter Lab No. _____																		

- Pre-Treatment**
- On-Treatment:** \_\_\_\_\_ months (routine monitoring)
- Query Viral Breakthrough:**  
(Provide viral load and dates for last two treatment samples)

1. \_\_\_\_\_ (Viral Load) \_\_\_\_\_ (Date Reported)
2. \_\_\_\_\_ (Viral Load) \_\_\_\_\_ (Date Reported)

- Post-Treatment:** \_\_\_\_\_ weeks/months

**Other relevant and clinical information**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This form is available at: <http://www.publichealthontario.ca/Requisitions>

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