

# SAMPLE BCCDC Virology Requisition Form

Fillable requisition form: <http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Labs/VI%20Req.pdf>



**Public Health Laboratory**  
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**Virology Requisition**



Write the **correct code** at the top of the form:

- LTC sites: "LTC"
- AL/IL sites: "CGT"
- \*Outbreak Sites: also add "OBK"**

**Section 1 - Patient/Provider Information** (Two matching unique patient numbers or sample container and requisition are required for sample processing)

PERSONAL HEALTH NUMBER (or out-of-province Health Number and province)		ORDERING PRACTITIONER	
PATIENT SURNAME		Address of report delivery	
PATIENT FIRST AND MIDDLE NAME		<input type="checkbox"/> I do not require a copy of the report (Locust, include name of Practitioner)	
DOB (DD/MM/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> U (unk)	ADDITIONAL COPIES TO PROVIDER (Name, Address / NSIC# / PISA Client#)	
PATIENT ADDRESS		1. _____	
CITY		2. _____	
PROVINCE	POSTAL CODE	DATE COLLECTED (DD/MM/YYYY)	TIME COLLECTED (HH:MM)

**Section 2 - Test(s) Requested**

**RESPIRATORY PATHOGENS**

Influenza A, Influenza B, RSV

COVID-19

MERS (Approval and travel history required\*)

Enterovirus D68 (Seasonal; when outside season, approval required)

Other, specify: \_\_\_\_\_

Indicate sample site:

Nasopharynx  Nares

Oropharynx  Throat

Lower Respiratory Tract: \_\_\_\_\_

Other, specify: \_\_\_\_\_

Indicate container type:

Swab with transport media

Saline gargle

Wash: \_\_\_\_\_

Others: \_\_\_\_\_

**PATIENT STATUS / TRAVEL HISTORY\* / EXPOSURE** (Please provide travel history where indicated\*)

\_\_\_\_\_

**OUTBREAK LOCATION / INFORMATION**

\_\_\_\_\_

**HERPES SIMPLEX 1,2 / VARICELLA ZOSTER VIRUSES**

Genital lesion swab  Non-genital lesion swab

Skin swab

Other, specify: \_\_\_\_\_

**ENCEPHALITIS VIRUSES**

Cerebrospinal Fluid for:

HSV 1, HSV 2, VZV and Enterovirus

West Nile virus (Seasonal) (Summer/early fall; when outside of season, specify travel history to endemic area\*)

Other, specify: \_\_\_\_\_

(Note: Send CSF from <6 months old directly to BC Children's & Women's Hospital Laboratory for testing that includes parainfluenza)

**GASTROINTESTINAL VIRUSES**

Feces\*\* for:

Gastrointestinal Panel (Norovirus, Adenovirus, Astrovirus, Rotavirus, Sapovirus)

Enterovirus

Other, specify: \_\_\_\_\_

\*\*Guideline for Ordering Stool Specimens: www.bccdc.ca/gpac/guideline\_starter.html

**VIRUS SUBTYPING**

Influenza A

Adenovirus (Surveillance/outbreak investigations only)

CT value: \_\_\_\_\_ or viral signal: weak / strong

**HEPATITIS VIRUSES**

Please see the [Serology Screening Requisition](#) to order HCV RNA and/or HCV genotyping testing.

**MEASLES**

Nasopharyngeal swab

Throat swab

Urine

Other, specify: \_\_\_\_\_

**MUMPS**

Buccal/Oral swab

Urine

Other, specify: \_\_\_\_\_

Recent MMR vaccination

Recent travel (Provide travel history if available\*)

**RUBELLA**

Nasopharyngeal washing/swab

Throat swab

Urine

Other, specify: \_\_\_\_\_

**BIOPSY / AUTOPSY / OTHER TESTS**

Plasma for West Nile virus (Seasonal)

Eye sample for Adenovirus, HSV 1, HSV 2, VZV

Other, specify: \_\_\_\_\_

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by these Acts.

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