BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Virology Requisition

Highlighted fields must be completed

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

PERSONAL HEALTH NUMBER
(or out-of province Health Number)

PATIENT ADDRESS

DATE RECEIVED

PATIENT SURNAME

LABORATORY USE ONLY

PATIENT FIRST AND MIDDLE NAME

CITY

PROVINCE

DOB DD MMM YYYY **SEX** M ☐ F ☐ X ☐ Unk ☐

POSTAL CODE

CONTACT NO. (XXX) XXX-XXXX

SAMPLE REF. NO.

DATE COLLECTED (DD/MMM/YYYY) Unk ☐

TIME COLLECTED (HH:MM) Unk ☐

ORDERING PRACTITIONER (Name, MSP#, Address of report delivery)

ADDITIONAL COPIES TO PRACTITIONER / CLINIC: (Limit of 3 copies available)
(Name, Address / MSP#/ PHSA Client#)
1.
2.
3.

☐ **I am a Locum** (provide name of Practitioner and Clinic to receive report)

SIGNATURE OF ORDERING PRACTITIONER

DATE SIGNED

Section 2 - Test(s) Requested

RESPIRATORY

Indicate sample site:

☐ Nasopharynx   ☐ Nares
☐ Oropharynx   ☐ Throat
☐ Lower Respiratory Tract: _____
☐ Other, specify: _____

Indicate container type:

☐ Swab with transport medium
☐ Saline gargle
☐ Other, specify: _____

Indicate test(s):

☐ COVID-19 (SARS-CoV-2)
☐ Influenza A, Influenza B, Respiratory syncytial virus
☐ Avian influenza (e.g. H5)
   (*Approval and exposure location required)
☐ Enterovirus D68
   (Approval required outside August to October)
☐ Other test, specify: _____

HEPATITIS

Please see the **Serology Screening Requisition** to order HCV RNA and/or HCV genotyping testing

REFERRAL LABORATORY USE ONLY VIRAL TYPING BY NAT/SEQUENCING

Virus: _____
Sample site: _____
Ct value: _____ OR viral signal: weak / strong
Additional information: _____

For available tests and sample collection information, refer to the Programs & Services Guide on the Public Health Laboratory's website: http://www.bccdc.ca/health-professionals/professional-resources/laboratory-services

SKIN / MUCOSAL

Indicate anatomical site: _____

Select one

☐ Skin Lesion   ☐ Mucosal Lesion   ☐ Mucosal Non-Lesion

Indicate test(s):

☐ Herpes simplex 1/ Herpes simplex 2 / Varicella zoster
   (HSV 1)   (HSV 2)   (VZV)
☐ Mpox
☐ Molluscum contagiosum
☐ Other test, specify: _____

ENCEPHALITIS

Cerebrospinal Fluid for:

☐ HSV 1, HSV 2, VZV and Enterovirus
☐ West Nile virus (Approval required outside July to September)
☐ Creutzfeldt-Jakob disease
☐ Other test, specify: _____

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

MEASLES, MUMPS, RUBELLA

☐ Recent MMR vaccination   ☐ Recent travel
                               (*Provide travel history)

MEASLES

☐ Nasal / Nasopharyngeal swab
☐ Throat swab
☐ Urine
☐ Other sample type, specify: _____

MUMPS

☐ Buccal / Oral swab
☐ Urine
☐ Other sample type, specify: _____

RUBELLA

☐ Nasopharyngeal washing / swab
☐ Throat swab
☐ Urine
☐ Other sample type, specify: _____

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*RELEVANT EXPOSURE / TRAVEL OR OTHER HISTORY
(Please provide clinical history where indicated)

_____
_____

OUTBREAK LOCATION / INFORMATION

_____
_____

GASTROINTESTINAL

Feces for:

☐ Gastrointestinal Viral Panel
   (Norovirus, Adenovirus, Astrovirus, Rotavirus, Sapovirus)
☐ Enterovirus
☐ Other test, specify: _____

OTHER TESTS

☐ Eye sample for Adenovirus, HSV 1, HSV 2, VZV
☐ Skin sample for Enterovirus
☐ Plasma for West Nile virus
☐ Other test, specify: _____

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Better health.