SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

Division of Biochemistry
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

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

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

For Canada Only
Health Card #:
Issuing Province:

Version:

IMMUNOLOGY

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.

REFERRING LABORATORY/ INSTITUTION

Name:	**Address:**
Telephone:	**Fax:**
Ordering Physician:	

SPECIMEN INFORMATION

Collection Date: _____ (DD/MM/YYYY)
Collection Time: _____ (hh:mm)
Referring Specimen/Reference #: _____

STORAGE/TRANSPORTATION

Send specimens frozen unless otherwise specified

CLINICAL INFORMATION/DIAGNOSIS (Please provide this information to support use of optimal lab protocol for testing)

IMMUNOSUPPRESSIVE THERAPIES GIVEN (Please provide this information to support result interpretation)

TEST(S) REQUESTED		SPECIMEN REQUIREMENTS	
Antibody assays			
Indirect immunofluorescence assays			
☐	Anti-dsDNA IgG, *Crithidia luciliae*	0.3 mL for 1 test or 0.6 mL min for several tests	Serum
☐	Anti-Endomysial antibody (EMA), IgA		
☐	Anti-Glomerular Basement Membrane (AGBM), IgG		
☐	Anti-Liver Kidney Microsomal Antibody (ALKM), IgG		
☐	Anti-Neutrophil cytoplasmic antibody (ANCA), IgG		
☐	Anti-nuclear Antibody (ANA), HEp-2 IgG		
☐	Anti-Parietal Cell antibody (APC), IgG		
☐	Anti-Smooth Muscle Antibody (ASMA), IgG		
☐	Anti-tissue Transglutaminase (tTG), IgA		

SickKids
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

Division of Biochemistry
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

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

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

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

IMMUNOLOGY

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.

TEST(S) REQUESTED		SPECIMEN REQUIREMENTS
Immunoassays		
☐ Anti-Cardiolipin, IgG	0.3 mL for 1 test or 0.6 mL min for several tests	Serum
☐ Anti-dsDNA, IgG		
☐ Anti-La, IgG		
☐ Anti-Myeloperoxidase (MPO), IgG		
☐ Anti-Proteinase 3 (PR3), IgG		
☐ Anti-RNP, IgG		
☐ Anti-Ro52, IgG		
☐ Anti-Ro60, IgG		
☐ Anti-Sm, IgG		
☐ Anti-Pneumococcal IgG ☐ Pre-vaccination ☐ Post-vaccination ☐ Unknown status	0.25 mL	Serum (Red top tube) – not shared with other immunoassays
Inflammatory markers		
☐ Soluble IL-2 Receptor (CD25)	2 aliquots of 0.3mL each	EDTA plasma
☐ **Cytokine Panel 1**		
☐ Interleukin 1 Beta (IL-1β)	2 aliquots of 0.3 mL each for any combination of IL-10, IL-18, IL-1 β and IL-6	EDTA plasma: special centrifugation requirements
☐ Interleukin 6 (IL-6)		
☐ Interleukin 10 (IL-10)		
☐ Interleukin 18 (IL-18)		
☐ **Cytokine Panel 2**		
☐ CD163 (Additional Charge-Not included in price of panel)	2 aliquots of 0.3 mL each for any combination of TNF-α, CXCL9, IFN- γ, and CD163	EDTA plasma: special centrifugation requirements
☐ CXCL9/MIG		
☐ IFN-Gamma (IFN-γ)		
☐ TNF-alpha (TNF-α)		

Laboratory Use: _____-_____ Date/time received (yyyy/mm/dd – hh:mm) SickKids Spec #

SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

Division of Biochemistry
555 University Avenue
Room 3642, Atrium
Toronto, ON, M5G 1X8, Canada

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

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

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

IMMUNOLOGY

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.

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: 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: _____

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

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

Name: _____

Address: _____

_____ Apt. #: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Additional Contact Information

Patient's phone # with area code:

_____

- or -

Guardian's phone # with area code:

_____