

*** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY ***

NAME OF PHYSICIAN ORDERING TEST: (LAST) (FIRST) REFERRING INSTITUTION NAME AND ADDRESS OR CODE: IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING: PHYSICIAN NAME: BILLING CODE: ADDRESS: CITY: PROV. POSTAL CODE TELEPHONE NO. FAX NO.	LOCATION (WARD): PATIENT NAME: (LAST) (FIRST) DATE OF BIRTH: SEX: <input type="checkbox"/> F <input type="checkbox"/> M DD/MM/YYYY FACILITY PATIENT ID NO.: PROVINCIAL HEALTH NO.: PHYSICIAN (PRINT): (LAST) (FIRST) COLLECTION DATE: COLLECTION TIME: COLLECTED BY: NAME / INITIALS SPECIMEN TYPE:
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HISTORY AND CLINICAL IMPRESSION REQUIRED:	SPECIMEN ID #
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ST. BONIFACE GENERAL HOSPITAL TESTS	HEALTH SCIENCES CENTRE TESTS
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ANA | Nuclear Ab (IgG)

Autoantibodies

DNA <input type="checkbox"/> DNA Ab (ss and ds DNA)	ACA <input type="checkbox"/> Centromeric Ab
APHL <input type="checkbox"/> Phospholipid Ab (IgG and IgM)	HIS <input type="checkbox"/> Histone Ab
GBM <input type="checkbox"/> Glomerular Basement Membrane Ab	PCA <input type="checkbox"/> Parietal Cell Ab
AMA <input type="checkbox"/> Mitochondrial Ab	ADA <input type="checkbox"/> Adrenal Ab (IgG)
SMA <input type="checkbox"/> Smooth Muscle Ab	
STR <input type="checkbox"/> Striated Muscle Ab	
ARA <input type="checkbox"/> Reticulin Ab (IgA and IgG)	
ASCA <input type="checkbox"/> Saccharomyces cerevisiae Ab (Mannan Ab, IgG, IgA, IgM)	
PPA <input type="checkbox"/> Pemphigus/Pemphigoid Ab (Skin Abs - IgG)	

Protein Quantitation

IGG/GIG <input type="checkbox"/> IgG
IGA/AIG <input type="checkbox"/> IgA
IGM/MIG <input type="checkbox"/> IgM
C3 <input type="checkbox"/> Complement C3
C4 <input type="checkbox"/> Complement C4
HPT/HAPT <input type="checkbox"/> Haptoglobin
CRP/ICRP <input type="checkbox"/> CRP
AAT <input type="checkbox"/> Alpha 1 Antitrypsin
APA <input type="checkbox"/> Apolipoprotein A
APB <input type="checkbox"/> Apolipoprotein B
RF <input type="checkbox"/> Rheumatoid Factor (RF)

Extractable Nuclear Antigens Panel
 includes:

SM <input type="checkbox"/> Sm (Smith) Ab
RNP <input type="checkbox"/> RNP (Ribonucleoprotein) Ab
SSB <input type="checkbox"/> SSB (La) Ab
SSA <input type="checkbox"/> SSA (Ro) Ab
SCL <input type="checkbox"/> Scl-70 Ab
JO1 <input type="checkbox"/> JO-1 Ab

Vasculitis Panel
 includes:

ANCA <input type="checkbox"/> Neutrophil Cytoplasmic Ab (cANCA, pANCA, IgG)
PR3 <input type="checkbox"/> Proteinase 3 Ab
MPO <input type="checkbox"/> Myeloperoxidase Ab
LF <input type="checkbox"/> Lactoferrin Ab

Monoclonal Protein Investigation

Initial Follow-up

SPE (serum) | (includes protein electrophoresis and M protein identification where applicable)

UPE (urine) | (M Protein identification where applicable)

Serum Viscosity
 (minimum 20 mL of whole blood required)

Gluten Sensitivity Panel
 includes:

AEM <input type="checkbox"/> Endomysial Ab (IgA)
AGA <input type="checkbox"/> Gliadin Ab (IgA)
TTG <input type="checkbox"/> Tissue Transglutaminase (IgA)

CH50 **Total Complement Activity**
 (freeze serum within 1 hr after collection in two small aliquots and keep frozen)

CEI **C1 Esterase Inhibitor**

Acetylcholine Receptor Ab

Serum Cryoglobulins
 (clot and keep all serum collected at 37°C)
 (for all tests when cryoglobulin is requested)

Immunophenotyping (SBGH and HSC)
 (Sodium heparin and EDTA — Store at RT)

FOUR/TB <input type="checkbox"/> CD4/CD8 subsets	TB <input type="checkbox"/> Enumeration Panel (T, B & NK cells)	OBRT <input type="checkbox"/> Oxidative Burst (Send to HSC only)
FLOW/TB <input type="checkbox"/> Leukemias and Lymphomas	PNH <input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria	PLTR <input type="checkbox"/> Reticulated Platelets (HSC only)

Additional Tests