Public Health Ontario | Santé publique Ontario

PUBLIC HEALTH ONTARIO LABORATORIES 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 plasma

2. For HBV DNA, complete **page 3** of this form and submit minimum 2.5 ml frozen serum or plasma

3. For HCV RNA and HBV DNA, complete **pages 2 and 3** of this form and submit with minimum **5.0 ml** frozen serum or plasma

Ensure that the following has been completed before submitting to PHL Laboratory:

☐ 2.5 ml frozen serum or plasma is provided *(if both HCV and HBV DNA requested, submit 5.0 ml frozen serum or 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 also appear on the Requisition

For further information:

1. Specimen Collection Guide and this form are available at www.publichealthontario.ca/testdirectory
2. Public Health Laboratories Customer Service Centre 416-235-6556 or toll free 1-877-604-4567

Ontario Agency for Health Protection and Promotion / Agence de protection et de promotion de la santé

PUBLIC HEALTH ONTARIO LABORATORIES HEPATITIS PCR REQUISITION

Minimum volume 2.5 mL serum or plasma, removed from clot within 4 hours and submitted frozen to PHL

Part A: HEPATITIS C (HCV) RNA

Clinician Information	Patient Information
Name _____	Surname _____
Billing Number _____	First Name _____
Address: _____	HIN _____ DOB _____
_____	Address: _____
_____	_____
_____	_____
Postal Code: _____	

PHL Lab Number _____ Date Received _____

☐ **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 below the clinical reason this test is being requested for diagnosis.

☐ ***Pre-Treatment:*** *Genotyping and Baseline viral load*

☐ **On Treatment:**
☐ **4 weeks** ☐ **8 weeks** ☐ **12 weeks** ☐ **Other Specify # of weeks in space provided: _____**

☐ **Post Treatment:** _____ weeks
(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).

Other relevant and clinical information

_____

_____

_____

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

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Minimum volume 2.5 mL serum or plasma, removed from clot within 4 hours and submitted frozen to PHL

Part B: HEPATITIS B (HBV) DNA

Clinician Information	Patient Information
Name _____	Surname _____
Billing Number _____	First Name _____
Address: _____	HIN _____ DOB _____
_____	Address: _____
_____	_____
_____	_____
Postal Code: _____	

PHL Lab Number _____ Date Received _____

☐ **Pre-Treatment**

☐ **On-Treatment:** _____ months (routine monitoring)

☐ **Query Viral Breakthrough:**

(provide viral load and dates for last two treatment samples)

1. _____ _____
   (Viral Load) (date)
2. _____ _____
   (Viral Load) (date)

☐ **Post-Treatment:** _____ months

Other relevant and clinical information

_____

_____

_____

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