SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

NEWBORN SCREENING REQUISITION

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 #: *Version:*
Issuing Province:

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.

Send-Out Instructions

Send this sample directly to SickKids. This sample is requested in follow up to a positive newborn screening result.

SPECIMEN COLLECTION INFORMATION

Date (YYYY-MM-DD)	**Time** (HH:MM)

Newborn Screening Requisition Required Information (Will be pre-filled by NBS Team)

Name:	**Ordering Physician:** **[To be filled by NBS Team]** _____
HCN:	**CC Results:** **[Referring Lab Institution or Fax #]** _____
SickKids MRN #:	**SickKids Newborn Screening Contact 416-813-7410** _____

Clinical Information/Diagnostic Indications (essential for adequate evaluation of test results)

All tests ordered below are to be prioritized as STAT
Please refer to the Sickkids test catalogue website for collection instructions

PLASMA or SERUM (Frozen sent on dry ice)	WHOLE BLOOD (Store and ship at 4°C within 24hrs)	URINE (Frozen sent on dry ice)
☐ **Homocysteine** Green Top (LiHep) or Red Top	☐ **Galactosemia Screen** Green Top (LiHep) Only	☐ **Urine Organic Acids**
☐ **Total and Free Carnitine** Green Top (LiHep) or Red Top	☐ **TBNK Immunophenotyping** Purple Top (EDTA) Only	☐ **Urine Amino Acids**
☐ **Amino Acids** Green Top (LiHep) or Red Top	☐ **Recent Thymic Emigrants** Purple Top (EDTA) Only	☐ **Urine Succinylacetone**
☐ **Biotinidase** Plasma Green Top (LiHep) Only		☐ **Urine Total and Free Carnitine**
☐ **Homocysteine** Green Top (LiHep) or Red Top		☐ **Urine Creatine Panel**
☐ **Methylmalonic acid in blood (MMA)** Green Top (LiHep) or Red Top		
☐ **Acylcarnitine** Green Top (LiHep) or Red Top		
☐ **17-OH Progesterone** Green Top (LiHep) or Red Top		
☐ **Renin** Purple Top (EDTA) Only		

Additional Testing

☐	
☐	

Lab Comments

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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' Genome Diagnostics Laboratory at 416-813-7200 x1 with billing inquiries.

How to complete the Billing Form:

- **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 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: _____

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

Option 2: Interm Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible.

- Only eligible verified IFHP will be accepted.
- Eligible patients are issued one of two possible IFHP eligibility documents: a Refugee Protection Claimant Document (with photo) (RPCD) or an Interim Federal Health Program Certificate (IFHC).
- All documentation must be current with acceptable client information, client ID (UCI #), expiry date, IFHP Effective date, IFHP expiry date, signature and photo.
- Specimens without proper documentation will NOT be accepted. For additional details on the IFHP program, visit www.cic.gc.ca/ifhp.

UCI#_____

ICD code *(lab use only)*:_____

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:

_____