



Alberta Children's Hospital
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Imprint Patient Card Here

Name:	Last	First
DOB:	/	/
Medical Record #	SEX:	
Patient's Address:	City	Province
	Postal Code	

REQUESTING PHYSICIAN(S)

REASON FOR REFERRAL (REQUIRED)	REFERRING HOSPITAL / LAB / CLINIC
	Ref. Sample ID# _____ TELEPHONE _____

TEST REQUESTED

(Go to "www.calgarylabservices.com/lab-services-guide/lab-tests/" for specimen requirements)

URINE	COLLECTION DATE & INITIALS	<input type="checkbox"/> random	<input type="checkbox"/> 24 hour <i>Total Volume</i>	BCG Sample #
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<input type="checkbox"/> N-Acetylaspartic Acid	<input type="checkbox"/> Amino Acids	<input type="checkbox"/> Carnitine, Total and Free	<input type="checkbox"/> HVA/VMA	<input type="checkbox"/> Metabolic Screen
<input type="checkbox"/> 3-Methylglutaconic Acid	<input type="checkbox"/> Methylmalonic Acid	<input type="checkbox"/> Mucopolysaccharides	<input type="checkbox"/> Oligosaccharides	<input type="checkbox"/> Organic Acids
<input type="checkbox"/> Orotic Acid	<input type="checkbox"/> Pipecolic Acid	<input type="checkbox"/> Purines & Pyrimidines	<input type="checkbox"/> Sialic Acid, Total & Free	<input type="checkbox"/> Other

PLASMA	COLLECTION DATE & TIME	INITIALS	BCG Sample #
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<input type="checkbox"/> Acylcarnitine Profile	<input type="checkbox"/> S-Adenosylmethionine/homocysteine (Must Book – 955-7380)	<input type="checkbox"/> Amino Acids *
<input type="checkbox"/> Biotinidase (serum preferred)	<input type="checkbox"/> Carnitine, Total & Free	<input type="checkbox"/> Homocysteine, Total *
<input type="checkbox"/> 3-Hydroxybutyric Acid	<input type="checkbox"/> 3-Methylglutaconic Acid	<input type="checkbox"/> Methylmalonic Acid
<input type="checkbox"/> Pipecolic Acid	<input type="checkbox"/> Purines & Pyrimidines	<input type="checkbox"/> Phenylalanine & Tyrosine
	<input type="checkbox"/> Very Long Chain Fatty Acids *	<input type="checkbox"/> Other

* 4 hour fast required

CSF	COLLECTION DATE & TIME	INITIALS	BCG Sample #
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<input type="checkbox"/> Amino Acids	<input type="checkbox"/> Glycine (plasma must be collected at same time)	<input type="checkbox"/> 3-Methylglutaconic Acid	<input type="checkbox"/> Pipecolic Acid
<input type="checkbox"/> Pyruvate (Must Book – 403-955-7380)		<input type="checkbox"/> Other	

WHOLE BLOOD	COLLECTION DATE & TIME	INITIALS	BCG Sample #
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<input type="checkbox"/> ADA and PNP	<input type="checkbox"/> Galactose-1-Phosphate Uridyl Transferase	<input type="checkbox"/> Galactose-1-Phosphate
<input type="checkbox"/> HGPRT/APRT	<input type="checkbox"/> Pyruvate (Must Book – 955-7380)	<input type="checkbox"/> WBC Half-Cystine Quantitation
<input type="checkbox"/> Other		

SERUM	COLLECTION DATE & TIME	INITIALS	BCG Sample #
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<input type="checkbox"/> Hexosaminidase A&B (serum)	<input type="checkbox"/> Other
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OTHER	COLLECTION DATE & TIME	INITIALS	BCG Sample #
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<input type="checkbox"/> T-Lymphocyte Culture Enzyme: _____	<input type="checkbox"/> Fibroblast Culture Reason: _____
<input type="checkbox"/> Tay Sachs Carrier Status (Must Book – 955-7380)	<input type="checkbox"/> Other

TO ASSIST IN INTERPRETATION

CLINICAL HISTORY

<input type="checkbox"/> Acidosis	<input type="checkbox"/> Ammonia	<input type="checkbox"/> Anion Gap	<input type="checkbox"/> Coma	<input type="checkbox"/> Dev. Delay
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Hypotonia	<input type="checkbox"/> Ketosis
<input type="checkbox"/> Lactate	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Premature	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vomiting

THERAPY & DIET FOR LAST 72 HOURS

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Carnitine	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Valproic Acid
<input type="checkbox"/> Breast Milk Only	<input type="checkbox"/> MCT Oil	<input type="checkbox"/> Normal Diet for Age	<input type="checkbox"/> TPN	<input type="checkbox"/> Transfusion (last 90 days)

Other Relevant Information: