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**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 <http://www.oahpp.ca/services/public-health-laboratories.html>
2. Public Health Laboratories Customer Service Centre 416-235-6556 or toll free 1-877-604-4567

**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**

<b>Clinician Information</b> Name _____  Billing Number _____ Address: _____ _____ _____  Postal Code: _____
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<b>Patient Information</b> Surname _____  First Name _____  HIN _____ DOB _____ Address: _____ _____ _____
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PHL Lab Number _____ Date Received _____
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- Pre-Treatment:** Query the presence of active HCV infection (HIV immunocompromised, infant of HCV positive mother, patient with anti- HCV indeterminate result, 8-10 weeks post exposure, etc).
- 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.oahpp.ca/resources/laboratory-materials.html>

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hours and submitted frozen to PHL**

**Part B: HEPATITIS B (HBV) DNA**

<b>Clinician Information</b> Name _____  Billing Number _____ Address: _____ _____ _____ Postal Code: _____
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<b>Patient Information</b> Surname _____  First Name _____  HIN _____ DOB _____ Address: _____ _____ _____
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PHL Lab Number _____	Date Received _____
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**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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