



Medical Directive

Title: Ordering of Laboratory Investigations and Immunizations as Part of Physicals or Other Examinations Requested by a Third Party

Assigned Number: 029

Activation Date: November 2021

Review due by: December 2023

Approval Signature & Date

Medical Director: [Signature] Date Reviewed: January 13, 2022

Executive Director: [Signature] Date Reviewed: January 13, 2022

Order and/or Delegated Procedure:

Appendix Attached: ☐ Yes ☒ No
Title:

Ordering of laboratory investigations requested by a third party (e.g., schools, camps, pre-school, daycare, fitness clubs, university, or other educational institution) as part of physicals or examinations by Registered Nurses/Registered Practical Nurses

Recipient Patients:

Appendix Attached: ☒ Yes ☐ No
Title:

All active patients of Thames Valley Family Health Team physicians, identified on the Authorizer Approval Form, who require laboratory investigations requested by a third party (e.g., schools, camps, pre-school, daycare, fitness clubs, university, or other educational institution) as part of physicals or examinations.

Authorized Implementers:	Appendix Attached: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Title:
Thames Valley Family Health Team Registered Nurses/ Registered Practical Nurses (RN/RPN) *.	
* The implementing RN/RPN must receive orientation from the Educator with regards to the task. The RN/RPN must sign the Implementer Performance Readiness Form in HR Downloads after successful completion of the orientation by the RN/RPN indicating acceptance of this medical directive.	
Indications:	Appendix Attached: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Title:
<ol style="list-style-type: none"> 1. Verbal consent received from the patient, or substitute decision maker, for the implementing RN/RPN to order the requested laboratory investigations. 2. Patient presents with a request from a third party for laboratory investigations (e.g., schools, camps, pre-school, daycare, fitness clubs, university, or other educational institution) as part of physicals or examinations 3. For laboratory requisition and prescribing of Hepatitis A/B and Varicella vaccines, be 16 years of age or older and require serologic proof of immunity to measles, mumps, rubella, varicella, hepatitis A and/or hepatitis B. 	
Contraindications:	
<ol style="list-style-type: none"> 1. No verbal consent from patient or substitute decision maker for RN/RPN to implement this medical directive. <p>Contraindications to laboratory requisition for immunity testing:</p> <ul style="list-style-type: none"> • Patient is currently symptomatic for the disease for which immunity is being tested • Post-exposure testing • Patient received a vaccine <4 weeks ago for the disease for which immunity is being tested • Patient has received gammaglobulin replacement within the past 5-6 months • Patient has received single doses of immunoglobulin within the past 3-5 months for the prevention of the disease for which immunity is being tested 	
Consent:	Appendix Attached: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Title:
<ol style="list-style-type: none"> 1. Patients of Thames Valley Family Health Team family physician. 2. RN/RPN obtains verbal patient consent prior to the implementation of care. 	

Guidelines for Implementing the Order/ Procedure:	Appendix Attached: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Title:
<ol style="list-style-type: none"> 1. Review relevant document to identify requested laboratory investigations requested as part of the physical or examination 2. Determine if any of the requested investigations are not OHIP-covered and discuss costs as appropriate with patient or substitute decision maker 3. Using appropriate requisitions to order the laboratory investigations <p>For laboratory requisition for immunity testing, implementer performs the following:</p> <ol style="list-style-type: none"> 1. Identifies need for laboratory investigation (bloodwork) 2. Ensures that no recent bloodwork has been undertaken that would result in duplication of testing 3. Explains the purpose of the test to the patient 4. Generates a laboratory requisition(s) using the appropriate documentation standards for TVFHT medical directives. 5. Documents that a laboratory requisition has been provided 6. Follows up with the results promptly when available and reviews these findings with the patient's primary care provider in a timely manner so that appropriate treatment or follow-up care is implemented when required. * <p>* Bloodwork results will be interpreted with caution in cases of immunodeficiency with the assistance of patient's primary care provider.</p> <p>For prescription of Hepatitis A/B and Varicella vaccines: Prior to preparing a prescription for vaccines, the implementer will assess for immunity against Hepatitis A/B or Varicella. If the patient has no history of vaccination or is found to be non-immune, the implementer will discuss with the patient vaccination details including the schedule, cost, and benefits/risks of each vaccine. The implementer will prepare a prescription for the chosen vaccine.</p>	
Documentation and Communication:	Appendix Attached: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Title:
<ol style="list-style-type: none"> 1. Documentation in the patient's medical record needs to include name and number of the directive, name of the implementer (including credential), and name of the physician/authorizer responsible for the directive and patient. 2. Information regarding implementation of the procedure and the patient's response should be documented in accordance with standard documentation practice* <p>* <i>Potter, P.A. & Perry, A.G. (2006). Fundamentals of Nursing. St. Louis: Mosby. College of Nurses of Ontario (2008). CNO Practice Standard: Documentation</i></p>	

Review and Quality Monitoring Guidelines:	Appendix Attached: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Title:
<ol style="list-style-type: none"> 1. The Directive remains in force until and unless amendment occurs. Review will occur biennially. In the case the Medical Director identifies the need to change the Medical Directive, at least one TVFHT member of the implementing disciplines will be consulted. 2. At any such time that issues related to the use of this directive are identified, the team must act upon the concerns immediately by identifying these concerns to the Medical Director. The Medical Director will review these concerns and consult with at least one TVFHT member of the implementing disciplines, before necessary changes are made. 3. If new information becomes available between routine renewals, and particularly if this new information has implications for unexpected outcomes, the directive will be reviewed by the Medical Director and a minimum of one implementing disciplines. 	
Approving Physician(s)/Authorizer(s):	Appendix Attached: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Title:
Authorizer Approval Form	

Appendix 3: Ordering Hepatitis A/B or Varicella Vaccinations

Vaccine	Dose	Route
Varicella (Varivax III)	0.5mL * Reconstituted with adjuvant before administration	Subcutaneous
Hepatitis A (Havrix 1440 and 720)	Adult Dose (16 and older): 1440u/mL Pediatric Dose (2-15 years old): 720u/0.5mL	Intramuscular
Hepatitis B (Engerix-B)	Adult Dose: 20mcg/mL Pediatric Dose: 10mcg/0.5mL	Intramuscular

Appendix 4: Recommended Format for a Prescription or Requisition Pursuant to a Directive

A prescription or requisition for laboratory specimen complete pursuant to a medical directive must include:

- Name and Number of the Directive
- Name of Authorizer
- Name and Signature of the Implementer

The following sample illustrates the recommended format for including this information. The format readily signifies to pharmacists that they have the proper order, permitting them to dispense the prescribed medication, in accordance with legislative and regulatory requirements. Should there be questions about the prescription the pharmacist would contact the implementer. If questions cannot be resolved the physician or authorizer would be contacted for clarification. The physician or authorizer is recorded as the prescriber. Where requested a copy of the medical directive can be forwarded to the pharmacist. The sample prescription is appended to the directive. The same convention would apply to requisitions received by medical laboratory technicians that are completed pursuant to a directive. The sample requisition is appended to the directive.

Dr. J.D. Authorizer, MD, CCFP.
Thames Valley Family Health Team
6-1385 North Routledge Park, London ON
N6H 5N5
519-473-0530

Date: March 1, 2010

Patient: Christa Jones, 100 Main Street, London

Engerix-B 20mcg/mL 3 doses at 0, 1 and 6 months

(Signature)

Dr. J.D. Authorizer, MD, CCFP /R.F. Jane Smith RN
(R.F. Jane Smith RN, TVFHT 020)

Medical Directive Available at: <https://thamesvalleyfht.ca/medical-directives>

Ontario Ministry of Health and Long-Term Care Laboratory Requisition Requisitioning Clinician / Practitioner		Laboratory Use Only	
Name			
Address			
Clinician/Practitioner Number		Clinician/Practitioner's Contact Number for Urgent Results ()	
CPSO / Registration No.		Service Date yyyy mm dd	
Check (✓) one: <input type="checkbox"/> OHP/Insured <input type="checkbox"/> Third Party / Uninsured <input type="checkbox"/> WSIB		Health Number Version Sex Date of Birth () () <input type="checkbox"/> M <input type="checkbox"/> F yyyy mm dd	
Additional Clinical Information (e.g. diagnosis)		Province Other Provincial Registration Number Patient's Telephone Contact Number ()	
<input type="checkbox"/> Copy to: Clinician/Practitioner Last Name First Name		Patient's Last Name (as per OHP Card)	
Address		Patient's First & Middle Names (as per OHP Card)	
		Patient's Address (including Postal Code)	
Note: Separate requisitions are required for cytology, histology / pathology and tests performed by Public Health Laboratory			
x Biochemistry		x Hematology	
Glucose <input type="checkbox"/> Random <input type="checkbox"/> Fasting		CBC	
HbA1C		Prothrombin Time (INR)	
Creatinine (eGFR)		Immunology	
Uric Acid		Pregnancy Test (Urine)	
Sodium		Mononucleosis Screen	
Potassium		Rubella	
ALT		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)	
Alk. Phosphatase		Repeat Prenatal Antibodies	
Bilirubin		Microbiology ID & Sensitivities (if warranted)	
Albumin		Cervical	
Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C & Cholesterol/HDL-C ratio; individual lipid tests may be ordered in the "Other Tests" section of this form)		Vaginal	
Albumin / Creatinine Ratio, Urine		Vaginal / Rectal - Group B Strep	
Urinalysis (Chemical)		Chlamydia (specify source):	
Neonatal Bilirubin:		GC (specify source):	
Child's Age: days hours		Sputum	
Clinician/Practitioner's tel. no. ()		Throat	
Patient's 24 hr telephone no. ()		Wound (specify source):	
Therapeutic Drug Monitoring:		Urine	
Name of Drug #1		Stool Culture	
Name of Drug #2		Stool Ova & Parasites	
Time Collected #1 hr. #2 hr.		Other Swabs / Pus (specify source):	
Time of Last Dose #1 hr. #2 hr.			
Time of Next Dose #1 hr. #2 hr.			
I hereby certify the tests ordered are not for registered in or out patients of a hospital.		Specimen Collection	
Authorizer: Dr. Smith		Time 24 hour clock Date yyyy/mm/dd	
Implementer: Jane Doe, RN		Fecal Occult Blood Test (FOBT) (check one)	
TVFHT medical directive #001		<input type="checkbox"/> FOBT (non GCC) <input type="checkbox"/> ColonCancerCheck FOBT (CCC) no other test can be ordered on this form	
x <u>Jane Doe, RN</u> October 4, 2021		Laboratory Use Only	
Clinician/Practitioner Signature Date			