Thames Valley
Family Health Team

Medical Directive

Title:	**Ordering of Laboratory Investigations and Immunizations Requested by a Third Party or During Periodic Health Examinations**	**Assigned Number:**	**029**
Activation Date:	**November 2021**	**Review due by:**	**December 2025**

Approval Signature & Date

Medical Director: _____ Date Reviewed: Feb 23, 2024

Executive Director: _____ Date Reviewed: Feb 23, 2024

Order and/or Delegated Procedure:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

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

Recipient Patients:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

All active patients of Thames Valley Family Health Team who require laboratory investigations requested by a third party (e.g., schools, camps, pre-school, daycare, fitness clubs, university, or other educational institution) or during periodic health examinations.

Authorized Implementers:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

Thames Valley Family Health Team Registered Nurses, and Registered Practical Nurses (RN/RPN) herein referred to as implementer.

∗ The implementer must receive orientation from the Educator with regards to the task. The implementer must have completed orientation and educational requirements of the Ordering of Laboratory Investigations and Immunizations Requested by a Third Party or During Periodic Health Examinations medical directive. The implementer must sign the Implementer Performance Readiness Form electronically via HR Downloads after successful completion of the orientation (and quiz, if applicable) indicating acceptance of this medical directive

Indications:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

1. Verbal consent received from the patient, or substitute decision maker, for the implementer 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) or presents for a periodic health examination
3. For laboratory requisition and prescribing of Hepatitis A/B, Varicella and Rabies vaccines, will require serologic proof of immunity to Measles, Mumps, Rubella, Varicella, Hepatitis A/B or Rabies.

Contraindications:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

1. No verbal consent from patient or substitute decision maker for the implementer to implement this medical directive.

Contraindications to laboratory requisition for immunity testing:

- Patient is currently symptomatic for the disease for which immunity is being tested
- Post-exposure testing
- Patient received a vaccine less than 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:** ☐ **Yes** ☒ **No** **Title:**

1. Patients of Thames Valley Family Health Team.
2. The implementer obtains verbal patient consent prior to the implementation of care.

Guidelines for Implementing the Order/ Procedure:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

1. Review relevant documents to identify requested laboratory investigations requested or required during a periodic health 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

For laboratory requisition for immunity testing, implementer performs the following:

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. Generate laboratory requisition(s) using the appropriate documentation standards for TVFHT medical directives. (See Appendix 2)
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. *

For immunizations:

1. Review the latest Recommended Immunization Schedules in the Canadian Immunization Guide (https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-1-key-immunization-information/page-13-recommended-immunization-schedules.html) and determine if recommended immunizations are required
2. If recommended immunizations are outstanding, 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(s).
3. For prescription of Hepatitis A/B, Varicella and Rabies vaccines:
    - Prior to preparing a prescription for vaccines, the implementer will assess for immunity against Hepatitis A/B, Varicella or Rabies. 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.

∗ Bloodwork results will be interpreted with caution in cases of immunodeficiency with the assistance of the patient's primary care provider.

Documentation and Communication:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

∗ 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 authorizer responsible for the directive and patient.
∗ Documentation needs to include all information that outlines the details of any prescriptions or requisitions provided to the patient.
∗ Information regarding implementation of the procedure and the patient's response should be documented in accordance with standard documentation practice*

∗ Potter, P.A. & Perry, A.G. (2022). Fundamentals of Nursing. North York: Elsevier Canada.
∗ Potter, P.A. & Perry, A.G. (2023). Canadian Fundamentals of Nursing. North York: Elsevier Canada.
∗ College of Nurses of Ontario (2008). CNO Practice Standard: Documentation

Review and Quality Monitoring Guidelines:	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

1. The Directive remains in force until and unless amendment occurs. Review will occur biennially. In 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 TVFHT member of the implementing disciplines.

Approving Authorizer(s):	**Appendix Attached:** ☐ **Yes** ☒ **No** **Title:**

Authorizer Approval Form signed in HR Downloads.

Thames Valley
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Appendix 1: Ordering Hepatitis A/B, Varicella and/or Rabies 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
Rabies (Imovax®, Rabavert®)	Adult Dose: 1.0 mL Pediatric Dose: 1.0 mL	Intramuscular

Appendix 2: 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

Name

Address

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results ( )

Service Date yyyy mm dd

Clinician/Practitioner Number | CPSO / Registration No.

Health Number | Version | Sex ☐ M ☐ F | Date of Birth yyyy mm dd

Check (✓) one:

☐ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

Province | Other Provincial Registration Number | Patient's Telephone Contact Number ( )

Additional Clinical Information *(e.g. diagnosis)*

Patient's Last Name *(as per OHIP Card)*

Patient's First & Middle Names *(as per OHIP Card)*

☐ Copy to: Clinician/Practitioner

Last Name First Name

Address

Patient's Address *(including Postal Code)*

Note: Separate requisitions are required for cytology, histology / pathology and tests performed by Public Health Laboratory

x	**Biochemistry**
	Glucose ☐ Random ☐ Fasting
	HbA1C
	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
	ALT
	Alk. Phosphatase
	Bilirubin
	Albumin
	Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C & Chol/HDL-C ratio; individual lipid tests may be ordered in the "Other Tests" section of this form)
	Albumin / Creatinine Ratio, Urine
	Urinalysis (Chemical)
	Neonatal Bilirubin:
	Child's Age: days hours
	Clinician/Practitioner's tel. no.( )
	Patient's 24 hr telephone no. ( )
	Therapeutic Drug Monitoring:
	Name of Drug #1
	Name of Drug #2
	Time Collected #1 hr. #2 hr.
	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.

Authorizer: Dr. Smith

Implementer: Jane Doe, RN

TVFHT medical directive #001

x *Jane Doe. RN* October 4, 2021

Clinician/Practitioner Signature Date

x	**Hematology**
	CBC
	Prothrombin Time (INR)
	Immunology
	Pregnancy Test (Urine)
	Mononucleosis Screen
	Rubella
	Prenatal: ABO, Rh(D), Antibody Screen (titre and ident. if positive)
	Repeat Prenatal Antibodies
	Microbiology ID & Sensitivities (if warranted)
	Cervical
	Vaginal
	Vaginal / Rectal – Group B Strep
	Chlamydia *(specify source)*:
	GC *(specify source)*:
	Sputum
	Throat
	Wound *(specify source)*:
	Urine
	Stool Culture
	Stool Ova & Parasites
	Other Swabs / Pus *(specify source)*:

Specimen Collection

Time *24 hour clock* Date *yyyy/mm/dd*

Fecal Occult Blood Test (FOBT) *(check one)*

☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

x	**Viral Hepatitis** *(check **one** only)*
	Acute Hepatitis
	Chronic Hepatitis
	Immune Status / Previous Exposure Specify: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

or order individual hepatitis tests in the "Other Tests" section below

Prostate Specific Antigen (PSA)

☐ Total PSA ☐ Free PSA

Specify one below:

☐ Insured – Meets OHIP eligibility criteria

☐ Uninsured – Screening: Patient responsible for payment

Vitamin D (25-Hydroxy)

☐ Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism

☐ Uninsured - Patient responsible for payment

Other Tests - one test per line

Laboratory Use Only