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	x	Hematology	x	Viral Hepatitis *(check **one** only)*
	Glucose ☐ Random ☐ Fasting		CBC		Acute Hepatitis
	HbA1C		Prothrombin Time (INR)		Chronic Hepatitis
	TSH		**Immunology**		Immune Status / Previous Exposure
	Creatinine (eGFR)		Pregnancy test (Urine)		*Specify:* ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
	Uric Acid		Mononucleosis Screen		
	Sodium		Rubella		
	Potassium		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)		or order individual hepatitis tests in the "Other Tests" section below
	Chloride				
	CK		Repeat Prenatal Antibodies		**Other Tests** – one test per line
	ALT		**Microbiology ID & Sensitivities (if warranted)**		
	Alk. Phosphatase				
	Bilirubin		Cervical		
	Albumin		Vaginal		
	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)		Vaginal / Rectal – Group B Strep		
			Chlamydia *(specify source)*:		
	Vitamin B12		GC *(specify source)*:		
	Ferritin		Sputum		
	Albumin / Creatinine Ratio, Urine		Throat		
	Urinalysis (Chemical)		Wound *(specify source)*:		
	Neonatal Bilirubin:		Urine		
	Child's Age: days hours		Stool Culture		
	Clinician/Practitioner's tel. no. ( )		Stool Ova & Parasites		
	Patient's 24 hr telephone no. ( )		Other Swabs / Pus *(specify source)*:		
	Therapeutic Drug Monitoring:				
	Name of Drug #1		Specimen Collection Time hr.		Specimen Collection Date *(yyyy/mm/dd)*
	Name of Drug #2				
	Time Collected #1 hr. #2 hr		**Fecal Occult Blood Test (FOBT)** *(check one only)*		
	Time of Last Dose #1 hr. #2 hr.		☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form		
	Time of Next Dose #1 hr. #2 hr.		***Laboratory Use Only***		

I hereby certify the tests ordered are not for registered in or out patients of a hospital.

X _____ _____
Clinician/Practitioner Signature Date