

<div style="display: flex; align-items: center;"> <div style="text-align: center;"> Ontario </div> <div style="margin-left: 10px;"> Ministry of Health and Long-Term Care Laboratory Requisition Requisitioning Clinician / Practitioner </div> </div>			Laboratory Use Only										
Name													
Address													
			Clinician/Practitioner's Contact Number for Urgent Results ()					Service Date <div style="display: flex; justify-content: space-between;"> yyyy mm dd </div>					
Clinician/Practitioner Number		CPSO / Registration No.		Health Number			Version	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth <div style="display: flex; justify-content: space-between;"> yyyy mm dd </div>			
Check (✓) one: <input type="checkbox"/> OHIP/Insured <input type="checkbox"/> Third Party / Uninsured <input type="checkbox"/> 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)									
<input type="checkbox"/> Copy to: Clinician/Practitioner <div style="display: flex; justify-content: space-between;"> Last Name First Name </div>				Patient's Address (including Postal Code)									
Address													

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

x	Biochemistry	x	Hematology	x	Viral Hepatitis (check one only)	
	Glucose <input type="checkbox"/> Random <input type="checkbox"/> Fasting		CBC		Acute Hepatitis	
	HbA1C		Prothrombin Time (INR)		Chronic Hepatitis	
	Creatinine (eGFR)		Immunology		Immune Status / Previous Exposure Specify: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	
	Uric Acid		Pregnancy Test (Urine)		or order individual hepatitis tests in the "Other Tests" section below	
	Sodium		Mononucleosis Screen			
	Potassium		Rubella			
	ALT		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)			
	Alk. Phosphatase		Repeat Prenatal Antibodies		Prostate Specific Antigen (PSA)	
	Bilirubin				<input type="checkbox"/> Total PSA <input type="checkbox"/> Free PSA	
	Albumin		Microbiology ID & Sensitivities (if warranted)		Specify one below:	
	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)		Cervical		<input type="checkbox"/> Insured – Meets OHIP eligibility criteria	
		Vaginal		<input type="checkbox"/> Uninsured – Screening: Patient responsible for payment		
	Albumin / Creatinine Ratio, Urine		Vaginal / Rectal – Group B Strep		Vitamin D (25-Hydroxy)	
	Urinalysis (Chemical)		Chlamydia (specify source):		<input type="checkbox"/> Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism	
	Neonatal Bilirubin:		GC (specify source):		<input type="checkbox"/> Uninsured - Patient responsible for payment	
	Child's Age: days hours		Sputum		Other Tests - one test per line	
	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			
			Time 24 hour clock		Date yyyy/mm/dd	
			Laboratory Use Only			
X Clinician/Practitioner Signature Date						