Ontario

**Ministry of Health and Long-Term Care**

**Laboratory Requisition**

Requisitioning Clinician / Practitioner

Name

Address

Clinician/Practitioner Number | CPSO / Registration No.

***Laboratory Use Only***

Clear Form

Clinician/Practitioner's Contact Number for Urgent Results

Service Date yyyy mm dd

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, ColonCancerCheck FIT test, 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.***

**x**

Clinician/Practitioner Signature Date

| x | Hematology |
|---|---|
| | CBC |
| | Prothrombin Time (INR) |
| | **Immunology** |
| | Pregnancy Test (Urine) |
| | Mononucleosis Screen |
| | Rubella |
| | Prenatal: ABO, RhD, 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 | Date

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

Print

  