

<div>Ontario<div>Ministry of Health</div><div>Laboratory Requisition</div><div>Requisitioning Clinician / Practitioner</div></div>		<div>Laboratory Use Only</div>									
Name											
Address											
		Clinician/Practitioner's Contact Number for Urgent Results						Service Date			
		(       )						yyyy	mm	dd	
Clinician/Practitioner Number	CPSO / Registration No.	Health Number				Version	Sex	Date of Birth			
							<input type="checkbox"/> M <input type="checkbox"/> F	yyyy	mm	dd	
<div>Check (✓) one:</div> <div><input type="checkbox"/> OHIP/Insured    <input type="checkbox"/> Third Party / Uninsured    <input type="checkbox"/> WSIB</div>		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)									
<div><input type="checkbox"/> Copy to: Clinician/Practitioner</div> <div>Last Name                      First Name</div>		Patient's Address (including Postal Code)									
Address											

Note: Separate requisitions are required for cytology, Ontario Cervical Screening Program HPV and cytology tests, histology/pathology, ColonCancerCheck FIT test, and tests performed for Public Health Laboratory.

<div>x</div> <div>Biochemistry</div>	<div>x</div> <div>Hematology</div>	<div>x</div> <div>Viral Hepatitis (check one only)</div>
<div>Glucose</div> <div><input type="checkbox"/> Random    <input type="checkbox"/> Fasting</div>	<div>CBC</div>	<div>Acute Hepatitis</div>
<div>HbA1C</div>	<div>Prothrombin Time (INR)</div>	<div>Chronic Hepatitis</div>
<div>Creatinine (eGFR)</div>	<div>Immunology</div>	<div>Immune Status / Previous Exposure</div>
<div>Uric Acid</div>	<div>Pregnancy Test (Urine)</div>	<div>Specify:    <input type="checkbox"/> Hepatitis A</div>
<div>Sodium</div>	<div>Mononucleosis Screen</div>	<div><input type="checkbox"/> Hepatitis B</div>
<div>Potassium</div>	<div>Rubella</div>	<div><input type="checkbox"/> Hepatitis C</div>
<div>ALT</div>	<div>Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)</div>	<div>or order individual hepatitis tests in the "Other Tests" section below</div>
<div>Alk. Phosphatase</div>	<div>Repeat Prenatal Antibodies</div>	<div>Prostate Specific Antigen (PSA)</div>
<div>Bilirubin</div>	<div>Microbiology ID &amp; Sensitivities (if warranted)</div>	<div><input type="checkbox"/> Total PSA    <input type="checkbox"/> Free PSA</div>
<div>Albumin</div>	<div>Cervical</div>	<div>Specify one below:</div>
<div>Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C &amp; Chol/HDL-C ratio; individual lipid tests may be ordered in the "Other Tests" section of this form)</div>	<div>Vaginal</div>	<div><input type="checkbox"/> Insured – Meets OHIP eligibility criteria</div>
	<div>Vaginal / Rectal – Group B Strep</div>	<div><input type="checkbox"/> Uninsured – Screening: Patient responsible for payment</div>
<div>Albumin / Creatinine Ratio, Urine</div>	<div>Chlamydia (specify source):</div>	<div>Vitamin D (25-Hydroxy)</div>
<div>Urinalysis (Chemical)</div>	<div>GC (specify source):</div>	<div><input type="checkbox"/> Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism</div>
<div>Neonatal Bilirubin:</div>	<div>Sputum</div>	<div><input type="checkbox"/> Uninsured - Patient responsible for payment</div>
<div>Child's Age:                      days                      hours</div>	<div>Throat</div>	<div>Other Tests - one test per line</div>
<div>Clinician/Practitioner's tel. no. (       )</div>	<div>Wound (specify source):</div>	
<div>Patient's 24 hr telephone no. (       )</div>	<div>Urine</div>	
<div>Therapeutic Drug Monitoring:</div>	<div>Stool Culture</div>	
<div>Name of Drug #1</div>	<div>Stool Ova &amp; Parasites</div>	
<div>Name of Drug #2</div>	<div>Other Swabs / Pus (specify source):</div>	
<div>Time Collected #1                      hr.    #2                      hr.</div>		
<div>Time of Last Dose #1                      hr.    #2                      hr.</div>		
<div>Time of Next Dose #1                      hr.    #2                      hr.</div>		
<div>I hereby certify the tests ordered are not for registered in or out patients of a hospital.</div>	<div>Specimen Collection</div>	
	<div>Time                      Date</div>	
	<div>24 hour clock                      yyyy/mm/dd</div>	
	<div>Laboratory Use Only</div>	
<div>x</div>		
<div>Clinician/Practitioner Signature</div>	<div>Date</div>	