



Ministry of Health
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 <input type="checkbox"/> M <input type="checkbox"/> F	yyyy	Date of Birth mm dd
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Check (✓) one:
 OHIP/Insured Third Party / Uninsured WSIB

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

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.

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 or order individual hepatitis tests in the "Other Tests" section below	
	Uric Acid		Pregnancy Test (Urine)			
	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 Specify one below: <input type="checkbox"/> Insured – Meets OHIP eligibility criteria <input type="checkbox"/> Uninsured – Screening: Patient responsible for payment	
	Albumin		Microbiology ID & Sensitivities (if warranted)		Vitamin D (25-Hydroxy)	
	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: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism <input type="checkbox"/> Uninsured - Patient responsible for payment	
	Albumin / Creatinine Ratio, Urine		Vaginal		Other Tests - one test per line	
	Urinalysis (Chemical)		Vaginal / Rectal – Group B Strep			
	Neonatal Bilirubin:		Chlamydia (specify source):			
	Child's Age: days hours		GC (specify source):			
	Clinician/Practitioner's tel. no. ()		Sputum			
	Patient's 24 hr telephone no. ()		Throat			
	Therapeutic Drug Monitoring:		Wound (specify source):			
	Name of Drug #1		Urine			
	Name of Drug #2		Stool Culture			
	Time Collected #1 hr. #2 hr.		Stool Ova & Parasites			
	Time of Last Dose #1 hr. #2 hr.		Other Swabs / Pus (specify source):			
	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	Specimen Collection					
	Time 24 hour clock		Date yyyy/mm/dd			
Laboratory Use Only						
Clinician/Practitioner Signature	Date					