

<b>Ministry of Health and Long-Term Care</b> <b>Laboratory Requisition</b> Requisitioning Clinician / Practitioner		<b>Laboratory Use Only</b>		
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 <input type="checkbox"/> M <input type="checkbox"/> F
		Date of Birth yyyy    mm    dd		
<b>Check (✓) one:</b> <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 Last Name                      First Name		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)		<b>Immunology</b>		Immune Status / Previous Exposure
	Uric Acid		Pregnancy Test (Urine)		Specify: <input type="checkbox"/> Hepatitis A
	Sodium		Mononucleosis Screen		<input type="checkbox"/> Hepatitis B
	Potassium		Rubella		<input type="checkbox"/> Hepatitis C
	ALT		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)		or order individual hepatitis tests in the "Other Tests" section below
	Alk. Phosphatase		Repeat Prenatal Antibodies		<b>Prostate Specific Antigen (PSA)</b>
	Bilirubin				<input type="checkbox"/> Total PSA <input type="checkbox"/> Free PSA
	Albumin		<b>Microbiology ID &amp; Sensitivities (if warranted)</b>		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
			Vaginal / Rectal – Group B Strep		<b>Vitamin D (25-Hydroxy)</b>
	Albumin / Creatinine Ratio, Urine		Chlamydia (specify source):		<input type="checkbox"/> Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism
	Urinalysis (Chemical)		GC (specify source):		<input type="checkbox"/> Uninsured - Patient responsible for payment
	Neonatal Bilirubin:		Sputum		<b>Other Tests - one test per line</b>
	Child's Age:                      days                      hours		Throat		
	Clinician/Practitioner's tel. no. (       )		Wound (specify source):		
	Patient's 24 hr telephone no. (       )		Urine		
	Therapeutic Drug Monitoring:		Stool Culture		
	Name of Drug #1		Stool Ova & Parasites		
	Name of Drug #2		Other Swabs / Pus (specify source):		
	Time Collected #1                      hr.                      #2                      hr.				
	Time of Last Dose #1                      hr.                      #2                      hr.				
	Time of Next Dose #1                      hr.                      #2                      hr.				
<b>I hereby certify the tests ordered are not for registered in or out patients of a hospital.</b>		<b>Specimen Collection</b>			
Time                      Date 24 hour clock                      yyyy/mm/dd					
<b>Laboratory Use Only</b>					
<b>X</b> Clinician/Practitioner Signature                      Date					