Ontario

Ministry of Health and Long-Term Care
Laboratory Requisition

Requisitioning Clinician / Practitioner

Name
JULIAN DALGLIESH

Address
236 Avenue Road
Toronto ON M5R 2J4

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results

Service Date yyyy mm dd

Clinician/Practitioner Number: **042491**

CPSO / Registration No.: **120676**

Health Number | Version | Sex: ☑ M ☐ F | Date of Birth yyyy mm dd: **2 0 0 2 0 8 0 7**

Check ( ) one:
☐ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

Province: **O N** | Other Provincial Registration Number

Patient's Telephone Contact Number: **(6 4 7) 9 9 7 6 8 4 3**

Additional Clinical Information *(e.g. diagnosis)*

Patient's Last Name *(as per OHIP Card)*: **X I A O**

Patient's First & Middle Names *(as per OHIP Card)*: **N A I H E**

☑ Copy to: Clinician/Practitioner
Last Name: TAM | First Name: NATHAN

Address
OHIP Physician Id: 046924, CPSO: 121789
343 COLLEGE STREET, TORONTO ON M5T 1S5

Patient's Address *(including Postal Code)*
85 CHARLES ST W
TORONTO M5S 1K9

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

x	Biochemistry
	Glucose ☐ Random ☐ Fasting
	HbA1C
X	Creatinine (eGFR)
	Uric Acid
X	Sodium
X	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.

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)*:

x	Viral Hepatitis *(check **one** only)*
	Acute Hepatitis
	Chronic Hepatitis
	Immune Status / Previous Exposure

Specify ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

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
ESR
CRP

I hereby certify the tests ordered are not for registered in or out patients of a hospital.

Specimen Collection
Time 24 hr clock | Date yyyy/mm/dd

x [signature] Clinician/Practitioner Signature — 03/10/2023 Date

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 7530-4581