Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

Adam Wayne

Address

Room 1101 75 Laurier Ave. E, Ottawa, ON, K1N 6N5

Clinician/Practitioner Number: 123456789-ABC

CPSO / Registration No.:

Check (✓) one:

☐ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

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

None

☐ Copy to: Clinician/Practitioner

Last Name First Name

Address

Laboratory Use Only

Clear Form

Clinician/Practitioner's Contact Number for Urgent Results: 6131231001

Service Date: yyyy mm dd

Health Number: 1 2 3 4 5 6 7 8 9 - Version:

Sex: ☑ M ☐ F

Date of Birth: yyyy 0 0 0 0 mm 0 0 dd 0 0

Province: ON

Other Provincial Registration Number: 1 2 3 4 5 6 7 8 9 - A B

Patient's Telephone Contact Number: 6131230037

Patient's Last Name *(as per OHIP Card)*: Green

Patient's First & Middle Names *(as per OHIP Card)*: Aiden Juan

Patient's Address *(including Postal Code)*: Apt. 137 3658 Hawthorne Road, Ottawa, ON, K1G 3N2

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.

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)*: bite
	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

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

Specimen Collection

Time Date

x

Clinician/Practitioner Signature Date

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