Ontario Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Confidential when Completed

Name

H. Ansari

Address

2291 Kipling Ave
Suite 117
Rexdale ON M9W-4L6

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results: (416) 741-4545 Ext.

Service Date: yyyy mm dd

Clinician/Practitioner Number	CPSO / Registration No.
052869	157085

Check (✓) one: [x] OHIP/Insured [ ] Third Party / Uninsured [ ] WSIB

Health Number	Version	Sex	Date of Birth (yyyy mm dd)
6 0 8 6 5 7 4 8 0 0	R L	[ ] M [x] F	1 9 9 2 0 9 0 4

Province	Other Provincial Registration Number	Patient's Telephone Contact Number
O N	0 0 1 1 0 5 4 9 - 0 0	(902) 989-5978

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

Patient's Last Name *(as per OHIP Card)*: M I T R A

Patient's First & Middle Names *(as per OHIP Card)*: K U H E L I

[ ] Copy to: Clinician/Practitioner

Last Name First Name

Address

Patient's Address *(including Postal Code)*

PH30 - 700 HUMBERWOOD BLVD
Rexdale ON M9W-7J4

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

X	Biochemistry
	Glucose [ ] Random [ ] Fasting
	HbA1C
	TSH
	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
	Chloride
	CK
	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)
	Vitamin B12
	Ferritin
	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)

X	Immunology
	Pregnancy test (Urine)
	Mononucleosis Screen
	Rubella
	Prenatal: ABO, RhD, Antibody Screen (titre and ident, if positive)
	Repeat Prenatal Antibodies

X	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)*:

Specimen Collection

Time *24 hour clock* Date *yyyy/mm/dd*

Fecal Occult Blood Test (FOBT) *(check one)*

[ ] FOBT (non CCC) [ ] ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

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*

IPS1

Laboratory Use Only

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

x H Ansari — Clinician/Practitioner Signature

23-Oct-2025 — Date

