Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name: Michael Kroll

Address: Credit Valley Family Health Team
2300 Eglinton Avenue West
Mississauga ON
L5M 2V8

Clinician/Practitioner Number: 254680

CPSO / Registration No.: 51002

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

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

☐ Copy to: Clinician/Practitioner
Last Name First Name

Address

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results

Service Date:

Health Number: 5045265393

Version: WY

Sex: ☐ M ☐ F

Date of Birth: yyyy 1963 mm 04 dd 27

Province: ON

Other Provincial Registration Number

Patient's Telephone Contact Number
Cell: (416) 414-8100
Home: (___) ___-____

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

Patient's First & Middle Names *(as per OHIP Card)*: RICHARD MARK

Patient's Address *(including Postal Code)*:
2350 WOODFIELD ROAD
OAKVILLE ON
L6H 6Y6

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.

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

Clinician/Practitioner Signature

Date: 2025-Sep-15

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)*:

Specimen Collection

Time

Date: MM/DD/YYYY

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

Laboratory Use Only

