For laboratory use only

Date received (yyyy/mm/dd):

PHOL No.

General Test Requistion

ALL Sections of this form must be completed at every visit

1. Submitter

Name:
test Test

Address:
West Bengal

City & Province :
Kolkata

Postal Code:

Courier Code:

Clinician initial / Surname and OHIP / CPSO No.:

Telephone:

Fax:

cc Doctor Qualified Health Care Provider Information

Name:

Tel:

Lab Name:

Fax:

CPSO No.:

Address:

Postal Code:

3. Test (s) Requested (Please see descriptions on reverse)

Test: Enter test description below:

Comment

4. Speciman Type and Site

☐ Blood / serum	☐ Faeces	☐ Nasopharyngeal
☐ Sputum	☐ Urine	☐ Vaginal Smear
☐ Urethral	☐ Cervix	☐ Bal
☐ Other (Specify):		

5. Reason For Test

☐ Diagnostic ☐ Post-mortem

Date Collected:

☐ Needle Stick ☐ Immune Status ☐ Prenatal

☐ Follow-up ☐ Bal ☐ Immunocompromised

☐ Chronic Condition ☐ Other (Specify): Onset Date:

For HIV, please use the HIV serology form. - For referred cultures, please use the reference bacteriology form. To re-order this test requisition contact your local Public Health Laboratory and ask for form number F-SD-SCG-1000. Current version of Public Health Laboratory requisitions are available at www.publichealthontario.ca/requisitions.

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36 (1)(c)(iii) for the purpose of clinical laboratory testing. If

2. Patient information

Health Card No.:

Gender:

○ Male

○ Female

Date of Birth: Medical Record No.:

First Name: LAst Name:

Address:

Postal Code: Phone No.:

Submitter Lab No.:

Public Heath Unit Outbreak No.:

Public Health Investigator Information

Name:

Name Unit:

Tel: Fax:

Hepatitis Serology

Reason For Test (Check Only One Box):

- [ ] Immune Status
- [ ] Acute Infection
- [ ] Chronic Infection

Indicate Specific Viruses (Check All That Apply):

- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C

Patient Setting

- [ ] Physician Office
- [ ] Inpatient (ICU)
- [ ] Inpatient (Ward)
- [ ] Institution
- [ ] ER (Not Admitted)

Clinical Information

- [ ] Fever
- [ ] Gastroenteritis
- [ ] Vesicular Rash
- [ ] STI
- [ ] Headache / Stiff Neck
- [ ] Maculopapular Rash
- [ ] Pregnant
- [ ] Enecephalitis / Meningitis
- [ ] Jaundice
- [ ] Respiratory Symptoms
- [ ] Other (Specify):
- [ ] Influenza High Risk (Specify):
- [ ] Recent Travel (Specify Location):

Dr. ABCD
Adresss: 1234 Back street
Signature:
Copy to:

Name

Email

Fax

License No.

Date