Ontario

**Ministry of Health and Long-Term Care**

**Laboratory Requisition**
Requisitioning Clinician / Practitioner

Name
Patrick O'Byrne NP

Address
GetaKit
179 Clarence St, Ottawa, ON, K1N 5P7
Tel: 613-234-4641 Fax: 613-691-7731

***Laboratory Use Only***

Clinician/Practitioner's Contact Number for Urgent Results ( )

Service Date yyyy mm dd

Clinician/Practitioner Number: 726399

CPSO / Registration No.: 0459768

Health Number | Version | Sex ☐M ☐F | Date of Birth yyyy mm dd: 1990 12 06

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

Province | Other Provincial Registration Number | Patient's Telephone Contact Number ( )

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

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

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

☒ Copy to: Clinician/Practitioner
Last Name: Catherine First Name: Watson RN(EC)

Address
Sexual Health Clinic
179 Clarence Street, Ottawa K1N 5P7
Tel: 613-234-4641 Fax: 613-580-2545
756512/190488 (CNO)

Patient's Address *(including Postal Code)*
650 Southmore Dr W, Ottawa, ON, K1V 7A1

Medical record #: CJCFI / File order #: 25-033278

***Note: Separate requisitions are required for cytology, histology / pathology 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)*: Urine |
| ☒ | GC *(specify source)*: Urine |
| | 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<br>*Specify:* ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C<br>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
Syphilis
HIV – serology

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

x _____ 2025-04-02
Clinician/Practitioner Signature Date

***Laboratory Use Only***
This requisition is only valid for 8 weeks from the date of ordering. Therefore, do not process this requisition after 2025-05-13.

  

# General Test Requisition

Public Health Ontario | Santé publique Ontario

**ALL sections** of the form must be completed by authorized health care providers for each specimen submitted, or testing may be delayed or cancelled.

Verify that **all testing requirements** are met before collecting a specimen.

For **HIV, respiratory viruses, or culture isolate** requests, use the dedicated requisitions available at: publichealthontario.ca/requisitions

**For Public Health Ontario's laboratory use only:**

Date Received (yyyy-mm-dd): | PHO Lab No.:

## Ordering Healthcare Provider Information

Licence No.: 0459768 | Healthcare Provider Full Name: Patrick O'Byrne NP

Org. Name: GetaKit | Address: 179 Clarence St

City: Ottawa | Postal Code: K1N 5P7 | Province: ON

Tel: 613-234-4641 | Fax: 613-691-7731

**Copy to Lab / Health Unit / Other Authorized Healthcare Provider**

Licence No.: 0190488 | Lab / Health Unit / Other Authorized Provider Name: Catherine Watson RN(EC)

Org. Name: Sexual Health Clinic | Address: 179 Clarence Street

City: Ottawa | Postal Code: K1N 5P9 | Province: ON

Tel: 613-234-4641 | Fax: 613-580-2545

## Patient Setting

- [ ] Clinic / Community
- [ ] ER (Not Admitted / Not Yet Determined)
- [ ] ER (Admitted)
- [ ] Inpatient (Non-ICU)
- [ ] ICU / CCU
- [ ] Congregate Living Setting

## Testing Indication(s) / Criteria

- [ ] Diagnosis
- [ ] Screening
- [ ] Immune Status
- [ ] Follow-up / Convalescent
- [ ] Pregnancy / Perinatal
- [ ] Impaired Immunity
- [ ] Post-mortem

Other (Specify):

## Signs / Symptoms

- [ ] No Signs / Symptoms

★ **Onset Date (yyyy-mm-dd):**

- [ ] Fever
- [ ] Rash
- [ ] STI
- [ ] Gastrointestinal
- [ ] Respiratory
- [ ] Hepatitis
- [ ] Meningitis / Encephalitis

Other (Specify):

## Relevant Exposure(s)

- [ ] None / Not Applicable

Most Recent Date (yyyy-mm-dd):

Occupational Exposure / Needlestick Injury (Specify): [ ] Source [ ] Exposed

Other (Specify):

## Relevant Travel(s)

- [ ] None / Not Applicable

Most Recent Date (yyyy-mm-dd):

Travel Details:

## Patient Information

Health Card No.:

Date of Birth (yyyy-mm-dd): 1990/12/06 | Sex: [X] Male [ ] Female

Medical Record No.: CJCFI

Last Name (per health card): Tokarchuk

First Name (per health card): Casey

Address: 650 Southmore Dr W | Postal Code: K1V 7A1

City: Ottawa | Tel:

**Investigation / Outbreak No. from PHO or Health Unit (if applicable):**

## Specimen Information

★ **Date Collected** (yyyy-mm-dd): | **Submitter Lab No.:** 25-033278

- [X] Whole Blood
- [ ] Serum
- [ ] Plasma
- [ ] Bone Marrow
- [ ] Cerebrospinal Fluid (CSF)
- [ ] Nasopharyngeal Swab (NPS)
- [ ] Oropharyngeal / Throat Swab
- [ ] Sputum
- [ ] Bronchoalveolar Lavage (BAL)
- [ ] Endocervical Swab
- [ ] Vaginal Swab
- [ ] Urethral Swab
- [ ] Urine
- [ ] Rectal Swab
- [ ] Faeces

Other (Specify type AND body location):

## Test(s) Requested

Enter each assay as per the publichealthontario.ca/testdirectory:

1. Syphilis
2.
3.

This requisition is only valid for 8 weeks from the date of ordering. Do not process this requisition after 2025-05-13.

**For routine hepatitis A, B or C serology, complete this section instead:**

**Hepatitis A**
- [ ] Immune Status (HAV IgG)
- [ ] Acute Infection (HAV IgM, signs/ symptoms info)

**Hepatitis B**
- [ ] Immune Status (anti-HBs)
- [ ] Chronic Infection (HBsAg + total anti-HBc)
- [ ] Acute Infection (HBsAg + total anti-HBc + IgM if total is positive)
- [ ] Pre-Chemotherapy Screening (anti-HBs + HBsAg + total anti-HBc)

**Hepatitis C**
- [ ] Current / Past Infection (HCV total antibodies) No immune status test for HCV is currently available.

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 you have questions about the collection of this personal health information please contact the PHO's Laboratory Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-1000, version 004 (September 2023).

Ontario

Public Health Ontario | Santé publique Ontario

# HIV Serology
# HIV PCR Test Requisition

**For laboratory use only**
Date received (yyyy/mm/dd):
PHOL No.:

**ALL Sections of this form must be completed at every visit**

## 1- Submitter

Patrick O'Byrne NP
GetaKit
179 Clarence St, Ottawa, ON, K1N 5P7
Tel: 613-234-4641 Fax: 613-691-7731

License No: 0459768

Submitter lab no. number (if applicable):

Clinician initial / Surname and OHIP / CPSO No.:

Telephone: | Fax:

**cc Doctor / Qualified Health Care Provider Information**

Name: Catherine Watson RN(EC) Telephone: 613.234.4641

Lab / Clinic Name: Sexual Health Clinic Fax:

CPSO No.: 756512/190488 (CNO)

Address: 179 Clarence Street, Ottawa | Postal Code: K1N 5P7

## 6 - Specimen Details

File #: 25-033278

Collection date of specimen (yyyy/mm/dd):

Type of specimen: ☒ Whole blood ☐ Dried blood spot (HIV PCR only) ☐ Serum ☐ ACD / EDTA ☐ Plasma

Tests requested: ☒ HIV1 / HIV2 ☐ HIV PCR (for infant diagnosis ≤18 months)

Comments: Do not process this requisition after 2025-05-13.

## 7 - Reason for Test (check all that apply)

- ☐ Routine
- ☐ Known to be HIV positive (repeat test)
- ☐ Symptoms - acute seroconversion (e.g. flu-like illness, fever, rash)
- ☐ Symptoms - advanced disease / AIDS
- ☐ Sexual assault
- ☐ Visa / immigration requirement
- ☐ Prenatal
- ☐ Pre-exposure prophylaxis
- ☐ Post-exposure prophylaxis
- ☐ Infant diagnosis ≤18 months
- ☐ Self-test; result: ☐ POS ☐ NEG ☐ Invalid
- ☐ Other, please specify:

## 8 - Previous Test Information

Last test result:
- ☐ Negative
- ☐ Positive (in Ontario)
- ☐ Positive (outside Ontario)
- ☐ Unknown
- ☐ Indeterminate

Previous PHOL sample no. (if available):

## 2 - Patient Information

Health Card No.:

Medical Record No.: CJCFI

Date of Birth (yyyy/mm/dd): 1990/12/06

Sex: ☒ M ◯ F ◯ TM* ◯ TF*
*TF = transfemale (M to F); TM = transmale (F to M)

Last Name: Tokarchuk | First Name: Casey

Address: 650 Southmore Dr W

City: Ottawa | Postal Code: K1V 7A1

PHO study or program no. (if applicable):

## 3 - Country of Birth:

## 4 - Race Ethnicity (check all that apply)

- ☐ White
- ☐ Black
- ☐ First Nations
- ☐ Métis
- ☐ Inuit
- ☐ South Asian (e.g. East Indian, Pakistani, Sri Lankan, Punjabi, Bangladeshi, Nepali)
- ☐ Other, please specify:
- ☐ Southeast / East Asian (e.g. Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent; Chinese, Korean, Japanese, Taiwanese descent)
- ☐ Arab / West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- ☐ Latin American (e.g. Mexican, Central / South American)

## 5 - Risk Factors (check all that apply)

- ☐ W Sex with women
- ☐ M Sex with men
- ☐ I Injection drug use
- ☐ E Born in an HIV-endemic country (includes countries in sub-Saharian Africa and the Caribbean)
- ☐ C Child of HIV+ mother
- ☐ O Other, please specify:

Sex with a person who was known to be:
- ☐ H HIV-positive
- ☐ I Using injection drugs
- ☐ E Born in an HIV-endemic country (includes countries in sub-Saharian Africa and the Caribbean)
- ☐ B A bisexual male

CONFIDENTIAL WHEN COMPLETED

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 you have questions about the collection of this personal health information please contact the PHO laboratory Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567.

Form No. F-SD-SCG-1001 (21/03/23).

Ontario