Ontario

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

**Laboratory Requisition**

Requisitioning Clinician / Practitioner

Name

Address

***Laboratory Use Only***

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

Service Date yyyy mm dd

Clinician/Practitioner Number | CPSO / Registration No.

Health Number | Version | Sex ☐ M ☐ F | Date of Birth yyyy mm dd

**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)*

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

☐ Copy to: Clinician/Practitioner

Last Name First Name

Address

Patient's Address *(including Postal Code)*

***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) |
| | **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)*: |
| | |

| 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:

☐ Meets OHIP eligibility criteria – Insured test

☐ Screening purposes – Uninsured test

**Other Tests** – one test per line

Specimen Collection Time hr.

Specimen Collection Date *(yyyy/mm/dd)*

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

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

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

x

Clinician/Practitioner Signature Date

***Laboratory Use Only***

  