



Laboratory Requisition
Requisitioning Physician/Practitioner

Laboratory Name and Address

Total Fee

Laboratory Accounting Number

Service Date	Ref. Lab.
yyyy mm dd	

Physician/Practitioner Number

Physician/Practitioner
Accounting Number

Health Number

Version	
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yyyy Date of Birth mm dd

Payment Program

Check (✓)
one:

☐ OHIP/Insured
☐ Third Party / Uninsured
☐ WSIB

Province| Other Registration Number

Patient's Phone Number

Patient's Last Name

Patient's First Name

Sex

Additional Clinical Information

Address

X	Biochemistry	Lab Code	Fee Code	X	Hematology	Lab Code	Fee Code	Other test, one per line (please type or print and use terminology of the Schedule of Benefits)			
	Glucose				Blood Film Exam				Lab Code	Fee Code	No. of serv.
	Creatinine				Hemoglobin						
	Uric Acid				W. B. C. count						
	Sodium				Hematocrit						
	Potassium				Prothromb. time						
	Chloride				Immunology						
	AST (SGOT)				Pregnancy test (urine)						
	Alk. Phosphatase				Heterophile antibodies screen						
	Bilirubin				Rubella						
	Cholesterol				Prenatal: ABO, RhD, antibody screen (titre and ident. if positive)						
	Triglyceride							Laboratory use only			
	Urinalysis (chemical)				Repeat Prenatal antibodies			Documentation Fee			
Viral Hepatitis (check <i>one</i> only) <input type="checkbox"/> Acute hepatitis <input type="checkbox"/> Chronic hepatitis <input type="checkbox"/> Immune status / prev. exposure Specify: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B					Prenatal Hepatitis B			Gyn. Specimen (Pap Smear)			
					VDRL						
					Microbiology Sensitivities if warranted						
					Cervical, vaginal						
					Sputum						
					Throat						
I certify the tests ordered are not for registered in or out patients of a hospital.					Urine						
					Stool culture						
					Other swabs						
X Signature _____ Date _____											

Confidential when completed