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, 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.

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:

☐ 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

FIB-4 Score

AST

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

x

Clinician/Practitioner Signature Date

Specimen Collection

Time Date

Laboratory Use Only

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