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)*

Drink 2 cups of water while fasting for 10 hours.

Complete NOW. REPEAT in 3 months.

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		
X	Glucose	☐ Random	☒ Fasting
X	HbA1C		
X	Creatinine (eGFR)		
X	Uric Acid		
X	Sodium		
X	Potassium		
X	ALT		
	Alk. Phosphatase		
	Bilirubin		
X	Albumin		
X	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)		
X	Albumin / Creatinine Ratio, Urine		
X	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
X	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)*:

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 *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

TSH

Urea

Vitamin B12 Level

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

X

Clinician/Practitioner Signature Date

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