Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

DR. ROLAND ISAAC SING

Address

4800 Leslie Street, Suite 204
North York, Ontario
M2J 2K9
Ph. 416-551-7070 Fx. 416-551-7171

Clinician/Practitioner Number	CPSO / Registration No.
012131	67015

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

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

Semen analysis following vasectomy. To be done approximately 3 months after procedure.

☒ Copy to: Clinician/Practitioner
Last Name First Name

Address

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

Service Date yyyy mm dd

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

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

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

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

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	Hematology	x	Viral Hepatitis *(check **one** only)*
	Glucose ☐ Random ☐ Fasting			CBC		Acute Hepatitis
	HbA1C			Prothrombin Time (INR)		Chronic Hepatitis
	Creatinine (eGFR)			**Immunology**		Immune Status / Previous Exposure *Specify*: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C or order individual hepatitis tests in the "Other Tests" section below
	Uric Acid			Pregnancy Test (Urine)		
	Sodium			Mononucleosis Screen		
	Potassium			Rubella		
	ALT			Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)		
	Alk. Phosphatase					**Prostate Specific Antigen (PSA)**
	Bilirubin			Repeat Prenatal Antibodies		☐ Total PSA ☐ Free PSA
	Albumin			**Microbiology ID & Sensitivities (if warranted)**		Specify one below: ☐ Insured – Meets OHIP eligibility criteria ☐ Uninsured – Screening: Patient responsible for payment
	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)			Cervical		
				Vaginal		**Vitamin D (25-Hydroxy)**
	Albumin / Creatinine Ratio, Urine			Vaginal / Rectal – Group B Strep		☐ Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism
	Urinalysis (Chemical)			Chlamydia *(specify source)*:		
	Neonatal Bilirubin:			GC *(specify source)*:		
	Child's Age: days hours			Sputum		☐ Uninsured - Patient responsible for payment
	Clinician/Practitioner's tel. no. ( )			Throat		**Other Tests** - one test per line
	Patient's 24 hr telephone no. ( )			Wound *(specify source)*:		Semen analysis - may do every 3 months
	Therapeutic Drug Monitoring:			Urine		as required.
	Name of Drug #1			Stool Culture		
	Name of Drug #2			Stool Ova & Parasites		
	Time Collected #1 hr.	#2 hr.		Other Swabs / Pus *(specify source)*:		
	Time of Last Dose #1 hr.	#2 hr.				
	Time of Next Dose #1 hr.	#2 hr.				

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

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

Verified by PDFfiller 05/10/2017

x R. I. Sing MD
Clinician/Practitioner Signature Date

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