Ontario Ministry of Health and Long-Term Care
Laboratory Requisition
Requisitioning Clinician / Practitioner

Name
Dr. Roland Sing
Address
4800 Leslie Street Suite 204
North York, M2J 2K9
T: (416) 551-7070 F: (416) 551-7171

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results: **(416) 551-7070**
Service Date: yyyy mm dd

Clinician/Practitioner Number	CPSO / Registration No.	Health Number	Version	Sex	Date of Birth (yyyy mm dd)
012131	67015			M	

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

Province	Other Provincial Registration Number	Patient's Telephone Contact Number

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

☑ Copy to: Clinician/Practitioner
Last Name First Name
Address

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

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.

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)*:

Specimen Collection
Time Date MM/DD/YYYY

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

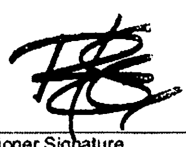
Vitamin D (25-Hydroxy)
- ☐ Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism
- ☐ Uninsured - Patient responsible for payment

Other Tests - one test per line
Semen Analysis /Post Vasectomy

Fecal Occult Blood Test (FOBT) *(check one)*
☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

Laboratory Use Only

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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