Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

Dr. Nikhil Pai

Address

3A21 - 1280 Main Street West, Hamilton, Ontario
L8S 4K1 f: 905-521-2655, p: 905-521-2100 x75637
urgent result: 905-521-2100 ask for Peds GI On-Call

Laboratory Use Only

Clear Form

Clinician/Practitioner's Contact Number for Urgent Results: (905) 521-2100

Service Date: yyyy mm dd

Clinician/Practitioner Number: 0000-032076

CPSO / Registration No.: 87227

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)*

Pediatric Gastroenterology & Nutrition Clinic
*Routine IBD Bloodwork

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	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)		**Prostate Specific Antigen (PSA)**
☒	Alk. Phosphatase			☐	Total PSA ☐ Free PSA
☒	Bilirubin	☐	Repeat Prenatal Antibodies		Specify one below:
☒	Albumin		**Microbiology ID & Sensitivities (if warranted)**	☐	Insured – Meets OHIP eligibility criteria
☐	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	☐	Uninsured – Screening: Patient responsible for payment
		☐	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)*:	☐	Uninsured - Patient responsible for payment
☐	Neonatal Bilirubin:	☐	GC *(specify source)*:		
☐	Child's Age: days hours	☐	Sputum		**Other Tests** - one test per line
☐	Clinician/Practitioner's tel. no. ( )	☐	Throat		Ferritin
☐	Patient's 24 hr telephone no. ( )	☐	Wound *(specify source)*:		Urea
☐	Therapeutic Drug Monitoring:	☐	Urine		Lipase
☐	Name of Drug #1	☐	Stool Culture		CRP
	Name of Drug #2	☐	Stool Ova & Parasites		ESR
	Time Collected #1 hr. #2 hr.	☐	Other Swabs / Pus *(specify source)*:		GGT
	Time of Last Dose #1 hr. #2 hr.	☐			*ATTENTION patients: please request stool collection containers from your clinic nurse if if required for sample collection.
	Time of Next Dose #1 hr. #2 hr.		**Specimen Collection** Time *24 hour clock* Date *yyyy/mm/dd*		

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

Fecal Occult Blood Test (FOBT) *(check one)*

☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

x Nikhil Pai

Clinician/Practitioner Signature Date

Laboratory Use Only

Print

