

Laboratory Use Only

Name _____
 Address _____

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 _____ Patient's Address (including Postal Code) _____

Address _____

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 <input type="checkbox"/> Random <input type="checkbox"/> Fasting		CBC		Acute Hepatitis
	HbA1C		Prothrombin Time (INR)		Chronic Hepatitis
	Creatinine (eGFR)		Immunology		Immune Status / Previous Exposure Specify: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C or order individual hepatitis tests in the "Other Tests" section below
	Uric Acid		Pregnancy Test (Urine)		Prostate Specific Antigen (PSA) <input type="checkbox"/> Total PSA <input type="checkbox"/> Free PSA
	Sodium		Mononucleosis Screen		
	Potassium		Rubella		Specify one below: <input type="checkbox"/> Insured – Meets OHIP eligibility criteria <input type="checkbox"/> Uninsured – Screening: Patient responsible for payment
	ALT		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)		
	Alk. Phosphatase		Repeat Prenatal Antibodies		Vitamin D (25-Hydroxy) <input type="checkbox"/> Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism <input type="checkbox"/> Uninsured - Patient responsible for payment
	Bilirubin		Microbiology ID & Sensitivities (if warranted)		Other Tests - one test per line
	Albumin		Cervical		
	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)		Vaginal		
	Albumin / Creatinine Ratio, Urine		Vaginal / Rectal – Group B Strep		
	Urinalysis (Chemical)		Chlamydia (specify source):		
	Neonatal Bilirubin:		GC (specify source):		
	Child's Age: _____ days _____ hours		Sputum		
	Clinician/Practitioner's tel. no. ()		Throat		
	Patient's 24 hr telephone no. ()		Wound (specify source):		
	Therapeutic Drug Monitoring:		Urine		
	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.				

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

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

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x 
 Clinician/Practitioner Signature _____ Date _____