Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

Address

Please Indicate the ordering physician's name and the address of the office to which the lab report is to be sent

Laboratory Use Only

LOCATION NUMBER STAMP

Clear Form

DO NOT STICK OR WRITE ANYTHING IN THIS SECTION

FOR LAB BARCODE USE ONLY

Clinician/Practitioner's Contact Number for Urgent Results

Service Date yyyy mm dd

Please include the ordering physician's OHIP Billing number

Clinician/Practitioner Number

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. dia*

If another doctor is to receive a copy of the results, please include their OHIP billing number, name, phone or fax, and complete clinic address

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

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

☐ Copy to: Clinician/Practitioner

Last Name Firs

Patient's Address *(including Postal Code)*

Please include patient's full address

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

The patient is required to fast a minimum of 8 to 12 hours

The patient will be asked to pay for any testing that is not covered by OHIP

Please indicate the time of last dose for any requested drug levels

Please provide specimen collection date and time

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

oratory Use Only

Signature must required in order to proceed with testing. (e-signature required initial of authorized person)

Requisition is considered expired if it is more than 6 months old for delayed or repeat.

Print

X

Clinician/Practitioner Signature

Date

