Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

Dr. Sharon Sula

Address

1479 Indian Grove
Mississauga Ontario
L5H2S5

Clinician/Practitioner Number: 230177

CPSO / Registration No.: 32256

Check (✓) one:

☒ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

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

☐ Copy to: Clinician/Practitioner

Last Name First Name

Address

Laboratory Use Only

Clear Form

Clinician/Practitioner's Contact Number for Urgent Results: (905) 274-7225

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, ColonCancerCheck FIT test, and tests performed by Public Health Laboratory

x	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.

x	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)*:

x	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

Rubella
HBsAg
Syphilis
HIV
TSH
Ferritin
Vitamin B12
B-HCG

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

Specimen Collection

Time | Date

x _____ _____

Clinician/Practitioner Signature Date

Laboratory Use Only

Print

