

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		
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	
Albumin / Creatinine Ratio, Urine	Vaginal	
Urinalysis (Chemical)	Vaginal / Rectal – Group B Strep	
Neonatal Bilirubin:	Chlamydia (specify source):	
Child's Age: _____ days _____ hours	GC (specify source):	
Clinician/Practitioner's tel. no. ()	Sputum	
Patient's 24 hr telephone no. ()	Throat	
Therapeutic Drug Monitoring:	Wound (specify source):	
Name of Drug #1	Urine	
Name of Drug #2	Stool Culture	
Time Collected #1 _____ hr. #2 _____ hr.	Stool Ova & Parasites	
Time of Last Dose #1 _____ hr. #2 _____ hr.	Other Swabs / Pus (specify source):	
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 _____