Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

Address

Laboratory Use Only

Clear Form

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

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**	
	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.

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

X

Clinician/Practitioner Signature Date

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)*:

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

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

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