

**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

Date of Birth  
 yyyy mm dd

M  F

**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	
	TSH		<b>Immunology</b>		Immune Status / Previous Exposure <i>Specify:</i> <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	
	Creatinine (eGFR)		Pregnancy test (Urine)			
	Uric Acid		Mononucleosis Screen			
	Sodium		Rubella			
	Potassium		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)		<b>Prostate Specific Antigen (PSA)</b> <input type="checkbox"/> Total PSA <input type="checkbox"/> Free PSA Specify one below: <input type="checkbox"/> Meets OHIP eligibility criteria – Insured test <input type="checkbox"/> Screening purposes – Uninsured test	
	Chloride		Repeat Prenatal Antibodies			
	CK		<b>Microbiology ID &amp; Sensitivities (if warranted)</b>		<b>Other Tests – one test per line</b>	
	ALT			Cervical		
	Alk. Phosphatase			Vaginal		
	Bilirubin		Vaginal / Rectal – Group B Strep			
	Albumin		Chlamydia ( <i>specify source</i> ):			
	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)		GC ( <i>specify source</i> ):			
	Vitamin B12		Sputum			
	Ferritin		Throat			
	Albumin / Creatinine Ratio, Urine		Wound ( <i>specify source</i> ):			
	Urinalysis (Chemical)		Urine			
	Neonatal Bilirubin:		Stool Culture			
	Child's Age:                      days                      hours		Stool Ova & Parasites			
	Clinician/Practitioner's tel. no. ( )		Other Swabs / Pus ( <i>specify source</i> ):			
	Patient's 24 hr telephone no. ( )					
	Therapeutic Drug Monitoring:					
	Name of Drug #1		Specimen Collection Time		Specimen Collection Date (yyyy/mm/dd)	
	Name of Drug #2		hr.			
	Time Collected #1                      hr.                      #2                      hr.		<b>Fecal Occult Blood Test (FOBT) (check one only)</b>			
	Time of Last Dose #1                      hr.                      #2                      hr.		<input type="checkbox"/> FOBT (non CCC) <input type="checkbox"/> ColonCancerCheck FOBT (CCC) no other test can be ordered on this form			
	Time of Next Dose #1                      hr.                      #2                      hr.		<b>Laboratory Use Only</b>			

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

**X**  
 Clinician/Practitioner Signature                      Date