

**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 \_\_\_\_\_ Patient's Address (including Postal Code) \_\_\_\_\_  
 Last Name First Name

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)		<b>Immunology</b>		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)		<b>Prostate Specific Antigen (PSA)</b> <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		<b>Vitamin D (25-Hydroxy)</b> <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		<b>Microbiology ID &amp; Sensitivities (if warranted)</b>		<b>Other Tests - one test per line</b>
	Albumin		Cervical		
	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		
	Albumin / Creatinine Ratio, Urine		Vaginal / Rectal – Group B Strep		
	Urinalysis (Chemical)		Chlamydia (specify source):		
	Neonatal Bilirubin:		GC (specify source):		
	Child's Age: _____ days _____ hours		Sputum		
	Clinician/Practitioner's tel. no. ( )		Throat		
	Patient's 24 hr telephone no. ( )		Wound (specify source):		
	Therapeutic Drug Monitoring:		Urine		
	Name of Drug #1		Stool Culture		
	Name of Drug #2		Stool 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.				

**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

**Laboratory Use Only**

**X**  
 Clinician/Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_