Ontario Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Laboratory Use Only

Clear Form

Name: DR JK DANIEL

Address:
427 PRESTON ST., SUITE 200
OTTAWA, ON
K1S 4N3

Clinician/Practitioner Number	CPSO / Registration No.
0000-042259-00	065396

Clinician/Practitioner's Contact Number for Urgent Results: (833) 646-7700

Service Date: yyyy mm dd

Health Number	Version	Sex	Date of Birth
		☐ M ☐ F	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)*

PLEASE FAX INTERPRETED ECG TO:
(613) 519-1574

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, 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

ECG

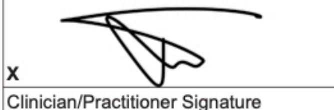
Specimen Collection

Time	Date

Laboratory Use Only

Print

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

x 

Clinician/Practitioner Signature Date

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