

<div>Ontario<div>Ministry of Health and Long-Term Care</div><div>Laboratory Requisition</div><div>Requisitioning Clinician / Practitioner</div></div> <div>Name</div> <div>ABBY Vantage</div> <div>Address</div> <div>123 Main St. Toronto, ON 12345</div>		<div>Laboratory Use Only</div>					
<div>Clinician/Practitioner Number</div> <div>15236</div>		<div>CPSO / Registration No.</div> <div>56845</div>		<div>Clinician/Practitioner's Contact Number for Urgent Results</div> <div>(555) 832-5555</div>		<div>Service Date</div> <div>yyyymmdd</div>	
<div>Health Number</div> <div>5453514884</div>		<div>Version</div> <div></div>		<div>Sex</div> <div><input type="checkbox"/> M<input checked="" type="checkbox"/> F</div>		<div>Date of Birth</div> <div>yyyymmdd</div> <div>20000101</div>	
<div>Check (✓) one:</div> <div><input checked="" type="checkbox"/> OHIP/Insured<input type="checkbox"/> Third Party / Uninsured<input type="checkbox"/> WSIB</div>		<div>Province</div> <div></div>		<div>Other Provincial Registration Number</div> <div></div>		<div>Patient's Telephone Contact Number</div> <div>(555) 555-5555</div>	
<div>Additional Clinical Information (e.g. diagnosis)</div> <div></div>		<div>Patient's Last Name (as per OHIP Card)</div> <div>T e s t</div> <div>Patient's First & Middle Names (as per OHIP Card)</div> <div>T e s t T e s t e r</div> <div>Patient's Address (including Postal Code)</div> <div>123 Main St. Toronto, ON 12345</div>					
<div><input type="checkbox"/> Copy to: Clinician/Practitioner</div> <div>Last NameFirst Name</div> <div>Address</div>							

Note: Separate requisitions are required for cytology, histology / pathology, ColonCancerCheck FIT test, and tests performed by Public Health Laboratory

<div>x</div> <div>Biochemistry</div> <div><input checked="" type="checkbox"/> Glucose<div><input checked="" type="checkbox"/> Random<input type="checkbox"/> Fasting</div></div> <div><input checked="" type="checkbox"/> HbA1C</div> <div><input checked="" type="checkbox"/> Creatinine (eGFR)</div> <div><input checked="" type="checkbox"/> Uric Acid</div> <div><input checked="" type="checkbox"/> Sodium</div> <div><input checked="" type="checkbox"/> Potassium</div> <div><input type="checkbox"/> ALT</div> <div><input type="checkbox"/> Alk. Phosphatase</div> <div><input type="checkbox"/> Bilirubin</div> <div><input type="checkbox"/> Albumin</div> <div><input checked="" type="checkbox"/> 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)</div> <div><input checked="" type="checkbox"/> Albumin / Creatinine Ratio, Urine</div> <div><input type="checkbox"/> Urinalysis (Chemical)</div> <div><input type="checkbox"/> Neonatal Bilirubin:</div> <div><div>Child's Age:div>daysdiv>hours</div></div> <div><div>Clinician/Practitioner's tel. no.</div></div> <div><div>Patient's 24 hr telephone no.</div></div>

Therapeutic Drug Monitoring:

Name of Drug #1

Name of Drug #2

Time Collected #1hr.#2hr.

Time of Last Dose #1hr.#2hr.

Time of Next Dose #1hr.#2hr.

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

x

Clinician/Practitioner Signature

2022/01/01

Date