

Address

Clinician/Practitioner's Contact Number for Urgent Results	
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Service Date

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Clinician/Practitioner Number	
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CPSO / Registration No.

Health Number	
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Version	
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Sex

Date of Birth

Check (✓) one:

☐ OHIP/Insured☐ Third Party / Uninsured

WSIB

Province	Other Provincial Registration Number
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Patient's Telephone Contact Number									
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Additional Clinical Information (e.g. diagnosis)

[illegible][illegible]☐ Copy to: Clinician/Practitioner☐ Copy to Last Name

First Name

[illegible]

Address

Note: Separate requisitions are required for cytology, histology / pathology, ColonCancerCheck FIT test, 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)				Immunology		Immune Status / Previous Exposure	
Uric Acid				Pregnancy Test (Urine)		Specify: <input type="checkbox"/> Hepatitis A	
Sodium				Mononucleosis Screen		<input type="checkbox"/> Hepatitis B	
Potassium				Rubella		<input type="checkbox"/> Hepatitis C	
ALT				Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)		or order individual hepatitis tests in the "Other Tests" section below	
Alk. Phosphatase				Repeat Prenatal Antibodies		Prostate Specific Antigen (PSA)	
Bilirubin				Microbiology ID & Sensitivities (if warranted)		<input type="checkbox"/> Total PSA <input type="checkbox"/> Free PSA	
Albumin						Specify one below:	
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)						<input type="checkbox"/> Insured – Meets OHIP eligibility criteria	
				<input type="checkbox"/> Uninsured – Screening: Patient responsible for payment			
				Vitamin D (25-Hydroxy)			
Albumin / Creatinine Ratio, Urine				Vaginal / Rectal – Group B Strep		<input type="checkbox"/> Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism	
Urinalysis (Chemical)				Chlamydia (specify source):		<input type="checkbox"/> Uninsured - Patient responsible for payment	
Neonatal Bilirubin:				GC (specify source):		Other Tests - one test per line	
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			
				Laboratory Use Only			
x							
Clinician/Practitioner Signature				Date			