Ontario **Ministry of Health and Long-Term Care**

Laboratory Requisition
Requisitioning Clinician / Practitioner

Name
DR NE POWER

Address
LHSC-VICTORIA HOSPITAL
800 COMMISSIONERS RD E E2-650
LONDON ON N6A5W9

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results ( )

Service Date yyyy mm dd

Clinician/Practitioner Number: **0000-027459-35**

CPSO / Registration No.: **097218**

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
Last Name First Name

Address

Patient's Address *(including Postal Code)*

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

x	Biochemistry
	Glucose ☐ Random ☐ Fasting
	HbA1C
	TSH
	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
	Chloride
	CK
	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)
	Vitamin B12
	Ferritin
	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)

x	Immunology
	Pregnancy test (Urine)
	Mononucleosis Screen
	Rubella
	Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)
	Repeat Prenatal Antibodies

x	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)*:

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

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

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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