Ontario  Ministry of Health and Long-Term Care Laboratory Requisition Requisitioning Clinician / Practitioner  Name					bo	ratory Use Only									
Add	ress														
					Clinician/Practitioner's Contact Number for Urgent Results						Service		44		
						)			уууу		mm I	dd I			
Clinician/Practitioner Number CPSO / Registration No.					alt	h Number	Version	Sex	(	100		of Birth	dd		
					ı				м 🔲 ғ	УУУ	/y 	mm 	du 		
Check (✓) one:  OHIP/Insured						Province Other Provincial Registration Number			Patier	nt's Telephon	e Conta	t Number	per		
					ı		,		1 1 1	1 1 1	1	1 1 1			
	Copy to: Clinician/Practitioner			Pa	tie	nt's Address (including Postal Code)									
Las	st Name First	Nam	е												
A do	Iress														
Add	ness														
Not	te: Separate requisitions are re	quir	ed for cytology, h	stolo	og	y / pathology and tests performed l	by Publ	ic H	lealth Lab	oratory					
х	Biochemistry			х		Hematology		х	Viral He	patitis (ch	eck <b>on</b> e	only)			
	Glucose Randor	n	Fasting		T	CBC			Acute He	patitis					
	HbA1C				T	Prothrombin Time (INR)			Chronic H	Hepatitis					
	Creatinine (eGFR)					Immunology				Status / Prev		osure			
	Uric Acid					Pregnancy Test (Urine)	Specify:	, L							
	Sodium Potassium					Mononucleosis Screen	Hepatitis B								
						Rubella				or order individual hepatitis tests in the					
	ALT				Prenatal: ABO, RhD, Antibody Screen				"Other Tests" section below						
	Alk. Phosphatase Bilirubin					(titre and ident. if positive)		Prostate Specific Antigen (PSA)							
						Repeat Prenatal Antibodies		☐ Total PSA ☐ Free PSA							
Albumin					Microbiology ID & Sensitivities				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)  Albumin / Creatinine Ratio, Urine					(if warranted)  Cervical			Insured – Meets OHIP eligibility criteria						
									Uninsured –	Screening: Pa	atient resp	onsible for	payment		
						Vaginal				Vitamin D (25-Hydroxy)					
						Vaginal / Rectal – Group B Strep		Insured - Meets OHIP eligibility criteria:							
	Urinalysis (Chemical)					Chlamydia (specify source):	osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes;								
	Neonatal Bilirubin:					GC (specify source):	medications affecting vitamin D metabolism Uninsured - Patient responsible for payment								
	Child's Age: days		hours	-	+	Sputum				•					
	Clinician/Practitioner's tel. no. (				+	Throat		0	ther Tests	s - one test	per line	1			
-	Patient's 24 hr telephone no. (	)			+	Wound (specify source):									
-	Therapeutic Drug Monitoring:				+	Urine Stool Culture									
ŀ	Name of Drug #1 Name of Drug #2				Stool Ova & Parasites Other Swabs / Pus (specify source):										
ŀ	Time Collected #1 hr. #2 hr.														
-	Time of Last Dose #1	hr.	#2 hr	_	+	Other Gwabs / Lus (specify source).									
ŀ	Time of Next Dose #1	hr.	#2 hr	-	ec	imen Collection									
I h	ereby certify the tests ordered are		1	_	ne	24 hour clock Date yyyy/mm/	/dd								
The state of the s					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										
х															
	nician/Practitioner Signature	_	Date												

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