Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

W

Address

226 Elm Street
St. Thomas, Ontario
N5R 1J5

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results

(519) 637-7617

Service Date yyyy mm dd

Clinician/Practitioner Number	CPSO / Registration No.
182477	

Health Number	Version	Sex	Date of Birth yyyy mm dd
ON 6183 846 770	TH	☒ M ☐ F	1940 01 24

Check (✓) one:

☒ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

Province	Other Provincial Registration Number	Patient's Telephone Contact Number
		(519) 633-8952

Additional Clinical Information *(e.g. diagnosis)*

Patient's Last Name *(as per OHIP Card)*

Larivee

Patient's First & Middle Names *(as per OHIP Card)*

Gary

☒ Copy to: Clinician/Practitioner

Last Name: WEINGERT First Name DR MICHAEL

Address

Patient's Address *(including Postal Code)*

21 ALDBOROUGH AVENUE
ST. THOMAS, ON
N5R 4S8

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
X	CK
X	ALT
	Alk. Phosphatase
	Bilirubin
	Albumin
X	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)
	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)*:

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

LATE MAY-EARLY JUNE

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

X _____ 02/05/2017

Clinician/Practitioner Signature Date

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