Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition
Requisitioning Clinician / Practitioner

Name
Magee, Bryden

Address
200 - 955 Green Valley Crescent
Ottawa,K2C 3V4
Ontario,Canada

Clinician/Practitioner Number: 034620
CPSO / Registration No.: 92938

Check (✓) one:
☑ OHIP/Insured ☐ Third Party / Uninsured ☐ WSIB

Additional Clinical Information *(e.g. diagnosis)*
DAY 19-21

84760

☐ Copy to: Clinician/Practitioner
Last Name First Name

Address

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results: 613-686-3378

Service Date: yyyy mm dd

Health Number: 5184743499 WJ
Version: WJ
Sex: ☐ M ☑ F
Date of Birth: 1989/09/18

Province: ON
Other Provincial Registration Number:
Patient's Telephone Contact Number: 613-678-3453

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

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

Patient's Address *(including Postal Code)*
3440 COUNTY RD 10
VANKLEEK HILL, ON, K0B 1R0

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

x	Biochemistry
☐	Glucose ☐ Random ☐ Fasting
☐	HbA1C
☐	Creatinine (eGFR)
☐	Uric Acid
☐	Sodium
☐	Potassium
☐	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)
☐	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)*:

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
	PROGESTERONE
	TSH
	HBSAg
	HEP C

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)

x 2021-05-03
Clinician/Practitioner Signature Date

Laboratory Use Only

4422-84 (2019/01) © Queen's Printer for Ontario, 2019 7530-4581