
 Ontario Ministry of Health and Long-Term Care Laboratory Requisition Requisitioning Clinician / Practitioner		Laboratory Use Only	
Name Magee, Bryden			
Address 200 - 955 Green Valley Crescent Ottawa, K2C 3V4 Ontario, Canada			
Clinician/Practitioner's Contact Number for Urgent Results 613-686-3378		Service Date yyyy mm dd	
Clinician/Practitioner Number 034620	CPSO / Registration No. 92938	Health Number 5184743499 WJ	Version WJ
		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of Birth 1989/09/18
Check (✓) one: <input checked="" type="checkbox"/> OHIP/Insured <input type="checkbox"/> Third Party / Uninsured <input type="checkbox"/> WSIB		Province ON	Other Provincial Registration Number
		Patient's Telephone Contact Number 613-678-3453	
Additional Clinical Information (e.g. diagnosis) ASAP		Patient's Last Name (as per OHIP Card) ROSS	
84760		Patient's First & Middle Names (as per OHIP Card) CAITLIN ALICE	
<input type="checkbox"/> Copy to: Clinician/Practitioner Last Name First Name		Patient's Address (including Postal Code) 3440 COUNTY RD 10 VANKLEEK HILL, ON, K0B 1R0	
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)
<input type="checkbox"/>	Glucose <input type="checkbox"/> Random <input type="checkbox"/> Fasting	<input type="checkbox"/>	CBC	<input type="checkbox"/>	Acute Hepatitis
<input type="checkbox"/>	HbA1C	<input type="checkbox"/>	Prothrombin Time (INR)	<input type="checkbox"/>	Chronic Hepatitis
<input type="checkbox"/>	Creatinine (eGFR)	Immunology		<input type="checkbox"/>	Immune Status / Previous Exposure Specify: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C or order individual hepatitis tests in the "Other Tests" section below
<input type="checkbox"/>	Uric Acid	<input type="checkbox"/>	Pregnancy Test (Urine)	Prostate Specific Antigen (PSA)	
<input type="checkbox"/>	Sodium	<input type="checkbox"/>	Mononucleosis Screen	<input type="checkbox"/>	Total PSA <input type="checkbox"/> Free PSA
<input type="checkbox"/>	Potassium	<input type="checkbox"/>	Rubella	Specify one below:	
<input type="checkbox"/>	ALT	<input type="checkbox"/>	Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)	<input type="checkbox"/>	Insured - Meets OHIP eligibility criteria
<input type="checkbox"/>	Alk. Phosphatase	<input type="checkbox"/>	Repeat Prenatal Antibodies	<input type="checkbox"/>	Uninsured - Screening: Patient responsible for payment
<input type="checkbox"/>	Bilirubin	Microbiology ID & Sensitivities (if warranted)		Vitamin D (25-Hydroxy)	
<input type="checkbox"/>	Albumin	<input type="checkbox"/>	Cervical	<input type="checkbox"/> Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism	
<input type="checkbox"/>	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"/>	Vaginal	<input type="checkbox"/> Uninsured - Patient responsible for payment	
<input type="checkbox"/>	Albumin / Creatinine Ratio, Urine	<input type="checkbox"/>	Vaginal / Rectal - Group B Strep	Other Tests - one test per line	
<input type="checkbox"/>	Urinalysis (Chemical)	<input checked="" type="checkbox"/>	Chlamydia (specify source): URINE		
<input type="checkbox"/>	Neonatal Bilirubin:	<input checked="" type="checkbox"/>	GC (specify source): URINE		
	Child's Age: days hours	<input type="checkbox"/>	Sputum		
	Clinician/Practitioner's tel. no.	<input type="checkbox"/>	Throat		
	Patient's 24 hr telephone no.	<input type="checkbox"/>	Wound (specify source):		
<input type="checkbox"/>	Therapeutic Drug Monitoring:	<input type="checkbox"/>	Urine		
	Name of Drug #1	<input type="checkbox"/>	Stool Culture		
	Name of Drug #2	<input type="checkbox"/>	Stool Ova & Parasites		
	Time Collected #1 hr. #2 hr.	<input type="checkbox"/>	Other Swabs / Pus (specify source):		
	Time of Last Dose #1 hr. #2 hr.				
	Time of Next Dose #1 hr. #2 hr.				
<i>I hereby certify the tests ordered are not for registered in or out patients of a hospital.</i>					
		Specimen Collection			
		Time <i>24 hour clock</i>	Date <i>yyyy/mm/dd</i>		
Laboratory Use Only					
x 		2021-05-03			
Clinician/Practitioner Signature		Date			