

Date received

PHOL No.

## General Test Requisition

ALL Sections of this Form MUST be Completed

<b>1 - Submitter</b> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="text-align: right;">Courier Code</p> <p>Magee, Bryden</p> <p>Ottawa Fertility Centre 200 - 955 Green Valley Crescent Ottawa, Ontario, K2C 3V4 Tel: 613-686-3378 Fax: 613-225-9736</p> </div> <p>Clinician Initial / Surname and OHIP / CPSO Number</p> <p>Tel: <u>613-686-3378</u> Fax: <u>613-225-9736</u></p> <p><b>cc Doctor Information</b></p> <p>Name: _____ Tel: _____ Lab/Clinic Name: _____ Fax: _____ CPSO #: _____ Address: _____ Postal Code: _____</p>	<b>2 - Patient Information</b> <table border="1" style="width: 100%;"> <tr> <td>Health No. 5184743499 WJ</td> <td>Sex F</td> <td>Date of Birth: 1989/09/18</td> </tr> <tr> <td>Medical Record No.</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Patient's Last Name (per OHIP card) ROSS</td> <td>First Name (per OHIP card) CAITLIN ALICE</td> </tr> <tr> <td colspan="3">Patient Address 3440 COUNTY RD 10 VANKLEEK HILL, ON, K0B 1R0</td> </tr> <tr> <td>Postal Code K0B 1R0</td> <td colspan="2">Patient Phone No. 613-678-3453</td> </tr> <tr> <td colspan="3">Submitter Lab No.</td> </tr> <tr> <td colspan="3">Public Health Unit Outbreak No.</td> </tr> </table> <p><b>Public Health Investigator Information</b></p> <p>Name: _____ Health Unit: _____ Tel: _____ Fax: _____</p>	Health No. 5184743499 WJ	Sex F	Date of Birth: 1989/09/18	Medical Record No.			Patient's Last Name (per OHIP card) ROSS		First Name (per OHIP card) CAITLIN ALICE	Patient Address 3440 COUNTY RD 10 VANKLEEK HILL, ON, K0B 1R0			Postal Code K0B 1R0	Patient Phone No. 613-678-3453		Submitter Lab No.			Public Health Unit Outbreak No.		
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<b>3 - Test(s) Requested</b> (Please see descriptions on reverse) Test: Enter test descriptions below <div style="border: 1px solid black; padding: 5px; min-height: 100px;"> <p>VDRL</p> </div>	<b>Hepatitis Serology</b> Reason for test (Check (✓) only one box): <input type="checkbox"/> Immune status <input type="checkbox"/> Acute infection <input type="checkbox"/> Chronic infection Indicate specific viruses (Check (✓) all that apply): <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C (testing only available for acute or chronic infection; no test for determining immunity to HCV is currently available)
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<b>4 - Specimen Type and Site</b> <input checked="" type="checkbox"/> blood / serum <input type="checkbox"/> faeces <input type="checkbox"/> nasopharyngeal <input type="checkbox"/> sputum <input type="checkbox"/> urine <input type="checkbox"/> vaginal smear <input type="checkbox"/> urethral <input type="checkbox"/> cervix <input type="checkbox"/> BAL <input type="checkbox"/> other - (specify)	<b>Patient Setting</b> <input type="checkbox"/> physician office/clinic <input type="checkbox"/> ER (not admitted) <input type="checkbox"/> inpatient (ward) <input type="checkbox"/> inpatient (ICU) <input type="checkbox"/> institution
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<b>5 - Reason for Test</b> <input checked="" type="checkbox"/> diagnostic <input type="checkbox"/> immune status    Date Collected: _____ <input type="checkbox"/> needle stick <input type="checkbox"/> follow-up <input type="checkbox"/> prenatal <input type="checkbox"/> chronic condition    Onset Date: _____ <input type="checkbox"/> immunocompromised <input type="checkbox"/> post-mortem <input type="checkbox"/> other - (specify)	<b>Clinical Information</b> <input type="checkbox"/> fever <input type="checkbox"/> gastroenteritis <input type="checkbox"/> respiratory symptoms <input type="checkbox"/> STI <input type="checkbox"/> headache / stiff neck <input type="checkbox"/> vesicular rash <input type="checkbox"/> pregnant <input type="checkbox"/> encephalitis / meningitis <input type="checkbox"/> maculopapular rash <input type="checkbox"/> jaundice <input type="checkbox"/> other - (specify) <input type="checkbox"/> influenza high risk - (specify) <input type="checkbox"/> recent travel - (specify location)
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For HIV, please use the HIV serology form. - For referred cultures, please use the reference bacteriology form. To re-order this test requisition contact your local Public Health Laboratory and ask for form number F-SD-SCG-1000. Current version of Public Health Laboratory requisitions are available at [www.publichealthontario.ca/requisitions](http://www.publichealthontario.ca/requisitions)

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36 (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHOL Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-1000 (08/2013)