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: [x] OHIP/Insured [ ] Third Party / Uninsured [ ] WSIB

Additional Clinical Information (e.g. diagnosis): 85159

[ ] 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: 7090954681 HE | Version: HE | Sex: [x] M [ ] F | Date of Birth: 1982/02/03

Province: ON | Other Provincial Registration Number: | Patient's Telephone Contact Number: 613-306-3453

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

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

Patient's Address (including Postal Code):
3440 COUNTY RD 10
Vankleek Hill, ON, K0B1R0

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

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.

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)*:

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

HBSAG
HEP C ANTIBODIES

Specimen Collection

Time: 24 hour clock | Date: yyyy/mm/dd

Laboratory Use Only

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

x [signature] 2021-05-03
Clinician/Practitioner Signature | Date

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