
 <b>Ontario</b> Ministry of Health and Long-Term Care <b>Laboratory Requisition</b> Requisitioning Clinician / Practitioner		<b>Laboratory Use Only</b>	
Name <b>Magee, Bryden</b>			
Address <b>200 - 955 Green Valley Crescent          Ottawa, K2C 3V4          Ontario, Canada</b>			
Clinician/Practitioner Number <b>034620</b>		CPSO / Registration No. <b>92938</b>	
Health Number <b>7090954681 HE</b>		Version <b>HE</b>	
Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Date of Birth <b>1982/02/03</b>	
Check (✓) one: <input checked="" type="checkbox"/> OHIP/Insured <input type="checkbox"/> Third Party / Uninsured <input type="checkbox"/> WSIB		Province <b>ON</b>	
Additional Clinical Information (e.g. diagnosis) <b>ASAP</b>		Other Provincial Registration Number	
<b>85159</b>		Patient's Telephone Contact Number <b>613-306-3453</b>	
<input type="checkbox"/> Copy to: Clinician/Practitioner Last Name First Name		Patient's Last Name (as per OHIP Card) <b>RIDEN</b>	
Address		Patient's First & Middle Names (as per OHIP Card) <b>THAILA</b>	
		Patient's Address (including Postal Code) <b>3440 COUNTY RD 10          Vankleek Hill, ON, K0B1R0</b>	

**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)	<b>Immunology</b>		<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)	<b>Prostate Specific Antigen (PSA)</b>	
<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	<b>Microbiology ID &amp; Sensitivities (if warranted)</b>		<b>Vitamin D (25-Hydroxy)</b>	
<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	<b>Other Tests - one test per line</b>	
<input type="checkbox"/>	Urinalysis (Chemical)	<input checked="" type="checkbox"/>	Chlamydia (specify source): <b>URINE</b>		
<input type="checkbox"/>	Neonatal Bilirubin:	<input checked="" type="checkbox"/>	GC (specify source): <b>URINE</b>		
	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>					
		<b>Specimen Collection</b>			
		Time	Date		
		24 hour clock	yyyy/mm/dd		
<b>Laboratory Use Only</b>					
x 		2021-05-03			
Clinician/Practitioner Signature		Date			