Ontario Ministry of Health and Long-Term Care

Laboratory Requisition
Requisitioning Clinician / Practitioner

Name
DR ME WEINGERT

Address
203-230 FIRST AVE
ST THOMAS ON N5R4P5

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results
( )

Service Date yyyy mm dd

Clinician/Practitioner Number	CPSO / Registration No.
0000-194449-60	028359

Health Number | Version | Sex ☐M ☐F | Date of Birth yyyy mm dd

Province | Other Provincial Registration Number

Patient's Telephone Contact Number ( )

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

Additional Clinical Information *(e.g. diagnosis)*

Larivee,Gary 55134
21 Aldborough Avenue
St. Thomas,N5R 4S8
(519)633-8952 ( ) - x
24-Jan-1940 M 6183846770TH
182477:Green, Jeff

☐ Copy to: Clinician/Practitioner
Last Name First Name

Address

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

x	Biochemistry
✓	Glucose ☐ Random ☐ Fasting
✓	HbA1C
	TSH
✓	Creatinine (eGFR)
✓	Uric Acid
✓	Sodium
✓	Potassium
✓	Chloride
✓	CK
✓	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)
	Vitamin B12
✓	Ferritin
	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)*:

Specimen Collection Time hr.

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:
☐ Meets OHIP eligibility criteria – insured test
☐ Screening purposes – Uninsured test

Other Tests – one test per line

Specimen Collection Date *(yyyy/mm/dd)*

Fecal Occult Blood Test (FOBT) *(check one only)*

☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

Laboratory Use Only

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

X Michael Weingertik
Clinician/Practitioner Signature Date