Ontario

Ministry of Health and Long-Term Care

Laboratory Requisition
Requisitioning Clinician / Practitioner

Name

Dr. Pete Lourenco, ACOST, MCOST, DO-Resident

Address

380 Wellington St, London, Ontario N6A 5B5
Canada

Clinician/Practitioner Number: +1 (437) 886-1466

CPSO / Registration No.: N.A.

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

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

Asymptomatic patient // Annual check-up
BMI ≥ 27%, HTN / T2D / HCL investigation panel

☒ Copy to: Clinician/Practitioner
Last Name: Lourenco
First Name: Dr. Pete
Address: DrPeteDO@pm.me

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results

Service Date yyyy mm dd

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

Province | Other Provincial Registration Number | Patient's Telephone Contact Number

Patient's Last Name *(as per OHIP Card)*

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

Patient's Address *(including Postal Code)*

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

x	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.	

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)*:

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

AST
Electrolytes:
-Total-CA
-P
-CL
-CO2
CRP-HS

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

x _____ _____
Clinician/Practitioner Signature Date

Specimen Collection

Time | Date

Laboratory Use Only

