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	CPSO / Registration No.
+1 (437) 886-1466	N.A.

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

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

Asymptomatic patient // Annual check-up
T2D / Prediabetes investigation panel
Patient with 1 or more diabetes risk factors

☒ Copy to: Clinician/Practitioner

Last Name	First Name
Lourenco	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
X	Glucose ☐ Random ☒ Fasting
X	HbA1C
X	Creatinine (eGFR)
X	Uric Acid
X	Sodium
X	Potassium
X	ALT
X	Alk. Phosphatase
X	Bilirubin
X	Albumin
X	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)
X	Albumin / Creatinine Ratio, Urine
X	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
X	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)*:

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:

☐ 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.

Specimen Collection

Time	Date

X
Clinician/Practitioner Signature Date

Laboratory Use Only

