



Ministry of Health and Long-Term Care

Laboratory Requisition  
Requisitioning Physician/Practitioner

Laboratory Number	Laboratory Name and Address		
Total Fee			
Laboratory Accounting Number	Service Date yyyy mm dd	Ref. Lab.	

Physician/Practitioner Number	Physician/Practitioner Accounting Number	Health Number	Version	Date of Birth yyyy mm dd	Payment Program
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Check (✓) one:

OHIP/Insured

Third Party / Uninsured

WSIB

Province	Other Registration Number	Patient's Phone Number
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Additional Clinical Information

Patient's Last Name	Patient's First Name	Sex
Address		

X	Biochemistry	Lab Code	Fee Code	X	Hematology	Lab Code	Fee Code	Other test, one per line (please type or print and use terminology of the Schedule of Benefits)	Lab Code	Fee Code	No. of serv.
	Glucose				Blood Film Exam						
	Creatinine				Hemoglobin						
	Uric Acid				W. B. C. count						
	Sodium				Hematocrit						
	Potassium				Prothromb. time						
	Chloride				<i>Immunology</i>						
	AST (SGOT)				Pregnancy test (urine)						
	Alk. Phosphatase				Heterophile antibodies screen						
	Bilirubin				Rubella						
	Cholesterol				Prenatal: ABO, RhD, antibody screen (titre and ident. if positive)			<i>Laboratory use only</i>			
	Triglyceride				Repeat Prenatal antibodies			Documentation Fee			
	Urinalysis (chemical)				Prenatal Hepatitis B			Gyn. Specimen (Pap Smear)			
	<b>Viral Hepatitis (check one only)</b>				VDRL						
	<input type="checkbox"/> Acute hepatitis				<i>Microbiology</i> Sensitivities if warranted						
	<input type="checkbox"/> Chronic hepatitis				Cervical, vaginal						
	<input type="checkbox"/> Immune status / prev. exposure				Sputum						
	Specify: <input type="checkbox"/> Hepatitis A				Throat						
	<input type="checkbox"/> Hepatitis B				Urine						
	I certify the tests ordered are not for registered in or out patients of a hospital.				Stool culture						
					Other swabs						
	X Signature _____ Date _____										

Confidential when completed