RAAM Clinic Toolkit

STANDARD INTAKE LAB REQUISITION

Ontario — Ministry of Health and Long-Term Care

Laboratory Requisition
Requisitioning Clinician / Practitioner

Name

Address

Clinician/Practitioner Number | CPSO / Registration No.

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)

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

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

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

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

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

☐ Copy to: Clinician/Practitioner
Last Name First Name

Address

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
	HbA1C
X	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
X	ALT
X	Alk. Phosphatase
X	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
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
X	Chlamydia *(specify source)*: urine
X	GC *(specify source)*: urine
	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
X	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

EKG
VDRL
HIV
urine for broad spectrum toxicology
urine BHCG

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

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