Ontario **Ministry of Health and Long-Term Care**

**Laboratory Requisition**
Requisitioning Clinician / Practitioner

Name
Dr. H. A. Pattinson

Address
8100 Twin Oaks Dr.
Windsor, ON
N8N 5C2

Clinician/Practitioner Number: 234898
CPSO / Registration No.: 67580

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

Additional Clinical Information *(e.g. diagnosis)*
INFERTILITY SCREENING LABS
MALE PARTNER

☐ Copy to: Clinician/Practitioner
Last Name First Name

Address

***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 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)*: |

**Specimen Collection** Time | Date

| x | **Viral Hepatitis** *(check one only)* |
|---|---|
| | Acute Hepatitis |
| | Chronic Hepatitis |
| | Immune Status / Previous Exposure<br>*Specify*: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C<br>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**
FSH
LH
FREE TESTOSTERONE

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

x _____ _____
Clinician/Practitioner Signature Date

**Fecal Occult Blood Test (FOBT)** *(check one)*
☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

***Laboratory Use Only***

Public Health Ontario | Santé publique Ontario

| Date received | PHOL No. |
|---|---|
| yyyy / mm / dd | |

# General Test Requisition

## ALL Sections of this Form MUST be Completed

### 1 - Submitter

Courier Code

Provide Return Address

Dr. H. A. Pattinson
8100 Twin Oaks Dr.
Windsor, ON
N8N 5C2

Clinician Initial / Surname and OHIP / CPSO Number
Pattinson 234898 / 67580

Tel: 519-974-9991 Fax: 519-974-2718

### 2 - Patient Information

| Health No. | Sex | Date of Birth: yyyy / mm / dd |
|---|---|---|
| Medical Record No. | | |
| Patient's Last Name *(per OHIP card)* | | First Name *(per OHIP card)* |
| Patient Address | | |
| Postal Code | Patient Phone No. | |
| Submitter Lab No. | | |
| Public Health Unit Outbreak No. | | |

### cc Doctor Information

Name: _____ Tel: _____
Lab/Clinic Name: _____ Fax: _____
CPSO #: _____
Address: _____ Postal Code: _____

### Public Health Investigator Information

Name: _____
Health Unit: _____
Tel: _____ Fax: _____

### 3 - Test(s) Requested *(Please see descriptions on reverse)*

**Test: Enter test descriptions below**

Hepatitis B Surface Antibody
Hepatitis B Surface Antigen
Hepatitis B Core
Hepatitis C
VDRL

### Hepatitis Serology

**Reason for test** (Check (✓) only one box):

- ☐ Immune status
- ☐ Acute infection
- ☐ Chronic infection

**Indicate specific viruses** (Check (✓) all that apply):

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C *(testing only available for acute or chronic infection; no test for determining immunity to HCV is currently available)*

### 4 - Specimen Type and Site

- ☑ blood / serum
- ☐ faeces
- ☐ nasopharyngeal
- ☐ sputum
- ☐ urine
- ☐ vaginal smear
- ☐ urethral
- ☐ cervix
- ☐ BAL
- ☐ other -

### Patient Setting

- ☑ physician office/clinic
- ☐ ER (not admitted)
- ☐ inpatient (ward)
- ☐ inpatient (ICU)
- ☐ institution

### 5 - Reason for Test

- ☐ diagnostic
- ☐ immune status
- ☐ needle stick
- ☐ follow-up
- ☐ prenatal
- ☐ chronic condition
- ☐ immunocompromised
- ☐ post-mortem
- ☑ other -

Date Collected: yyyy / mm / dd

Onset Date: yyyy / mm / dd

### Clinical Information

- ☐ fever
- ☐ gastroenteritis
- ☐ respiratory symptoms
- ☐ STI
- ☐ headache / stiff neck
- ☐ vesicular rash
- ☐ pregnant
- ☐ encephalitis / meningitis
- ☐ maculopapular rash
- ☐ jaundice
- ☐ other -

- ☐ influenza high risk -
- ☐ recent travel -

**For HIV, please use the HIV serology form. - For referred cultures, please use the reference bacteriology form. To re-order this test requisition contact your local Public Health Laboratory and ask for form number F-SD-SCG-1000. Current version of Public Health Laboratory requisitions are available at www.publichealthontario.ca/requisitions**

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36 (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHOL Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-1000 (08/2013)

Ontario

Public Health Ontario | Santé publique Ontario

**For laboratory use only**

Date received | PHOL No.

# HIV and HTLVI/HTLVII Serology HIV PCR Test Requisition

ALL Sections of this Form MUST be Completed

## Submitter

**Courier Code**

Dr. H. A. Pattinson
8100 Twin Oaks Dr.
Windsor, ON
N8N 5C2

Submitter lab no. (if applicable):

Clinician Initial / Surname and OHIP / CPSO Number
Pattinson 234898 / 67580

Tel: 519-974-9991 Fax: 519-974-2718

### cc Doctor/Qualified Health Care Provider Information

Name: _____ Tel: _____

Lab/Clinic name: _____

_____ Fax: _____

CPSO #: _____

Address: _____

Postal code:

## Specimen Details

Collection date of specimen: _____

Type of specimen: ☐ Whole blood ☐ Serum ☐ ACD/EDTA ☐ Plasma ☐ Dried blood spot (HIV PCR only)

Tests requested: ☑ HIV1/HIV2 ☑ HTLVI/HTLVII ☐ HIV PCR (for infant diagnosis ≤18 mos)

Comments:

## Reason for Test (check all that apply)

- ☐ Routine
- ☐ Known to be HIV positive (repeat test)
- ☐ Symptoms - acute seroconversion (e.g. flu-like illness, fever, rash)
- ☐ Symptoms - advanced disease/AIDS
- ☐ Sexual assault
- ☐ Visa/immigration requirement
- ☐ Prenatal
- ☐ Pre-exposure prophylaxis
- ☐ Post-exposure prophylaxis
- ☐ Infant diagnosis ≤18 mos
- ☑ Other, specify: Infertility

## Previous Test Information

Last test result:

- ☐ Negative
- ☐ Positive (in Ontario)
- ☐ Positive (outside Ontario)
- ☐ Unknown
- ☐ Indeterminate
- ☐ Previous PHOL sample no.: _____

## Patient Information

| | |
|---|---|
| Health card no.: | Medical record no. (if applicable): |
| Date of Birth: | Sex: ☐ F ☐ M ☐ TF* ☐ TM* *TF=transfemale (M to F); TM=transmale (F to M) |
| Last name: | First name: |
| Address: | |
| City: | Postal code: |
| PHO study or program no. (if applicable): | |
| Country of birth: | |

## Race/Ethnicity:

- ☐ White
- ☐ Black
- ☐ First Nations ☐ Métis ☐ Inuit
- ☐ South Asian (e.g. East Indian, Pakistani, Sri Lankan, Punjabi, Bangladeshi, Nepali)
- ☐ Southeast Asian (e.g. Chinese, Japanese, Vietnamese, Cambodian, Indonesian, Korean, Filipino)
- ☐ Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- ☐ Latin American (e.g. Mexican, Central/South American)
- ☐ Other - includes mixed ethnicity; specify:

## Risk Factors (check all that apply)

- ☐ Sex with women
- ☐ Sex with men
- ☐ Injection drug use
- ☐ Born in an HIV-endemic country (includes countries in sub-Saharan Africa and the Caribbean)
- ☐ Child of HIV+ mother

Sex with a person who was known to be (check all that apply)

- ☐ HIV-positive
- ☐ Using injection drugs
- ☐ Born in an HIV-endemic country (includes countries in sub-Saharan Africa and the Caribbean)
- ☐ A bisexual male

☐ Other (e.g. clotting factor, blood transfusion, needle stick/occupational, tattoo, piercing), please specify:

## CONFIDENTIAL WHEN COMPLETED

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