Ontario

Ministry of Health and Long-Term Care
Laboratory Requisition

Requisitioning Clinician / Practitioner

Name
Dr.R. Kirubaharan
Address
2 Fenton Rd, Unit 4
Markham
Ontario, L3R 7B4
Phone: 905-948-9455, Fax: 905-948-0570

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results: **Phone: 905-948-9455, Fax: 905-948-0570**

Service Date: **2022-02-24**

Clinician/Practitioner Number: **0000-014614-00**

CPSO / Registration No.: **073526**

Health Number: **1395547563**

Version: **WL**

Sex: [X] M [ ] F

Date of Birth: **1950-02-27**

Check (X) one: [X] **OHIP/Insured** [ ] **Third Party/Uninsured** [ ] **WSIB**

Province: **Ontario**

Other Provincial Registration Number: **071081**

Patient's Telephone Contact Number: **Tel.: 647-705-3775**

Additional Clinical Information (e.g. diagnosis)

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

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

[ ] Copy to: Clinician/Practitioner
Last Name First Name

Address

Patient's Address (including Postal Code)

18 WILLOUGHBY PLACE
BOWMANVILLE
Ontario, L1C0W4

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

x	Biochemistry
	Glucose [ ] Random [ ] Fasting
x	HbA1C
x	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
x	ALT
	Alk. Phosphatase
	Bilirubin
	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)
	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
	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 *24 hour clock* Date *yyyy/mm/dd*

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

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
TSH

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

X R. K 24/02/2022

Clinician/Practitioner Signature Date

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