

MOHLTC Requisition Essential Information

To be completed fully and clearly by the submitting health care provider

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

The form is a requisition form for the Ministry of Health and Long-Term Care, Ontario. It is divided into several sections:

- Header:** Includes the Ontario logo and the text "Ministry of Health and Long-Term Care Laboratory Requisition Requisitioning Clinician / Practitioner". A "Clear Form" button is in the top right.
- Provider Information:** Fields for Name (1), Address (1), and Clinician/Practitioner Number (2). CPDO / Registration No. is also present.
- Patient Information:** Fields for Health Number (7), Version (8), Sex (9), Service Date (6), Date of Birth (10), and Patient's Telephone Contact Number (11).
- Clinical Information:** A section for "Additional Clinical Information (e.g. diagnosis)" (3). A "Copy to: Clinician/Practitioner" section includes Last Name and First Name (4).
- Test Selection:** A grid of checkboxes for various tests:
 - Biochemistry:** Glucose (with Random and Fasting options), HbA1c, Creatinine (eGFR), Uric Acid (15), Sodium, Potassium, ALT, ALP, Phosphatase, Bilirubin, Albumin, Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, Calculated LDL-C & Chd-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 and hours), and Clinician/Practitioner's tel. no. ()
 - 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 Strip, Chlamydia (specify source): (16), GC (specify source): Sputum, Throat, Wound (specify source): Urine, Stool Culture, Stool Ova & Parasites, Other Swabs / Pus (specify source):
 - 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), Vitamin D (25-Hydroxy) (17) (Insured - Meets OHIP eligibility criteria, osteopenia, osteoporosis, rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism; Uninsured - Patient responsible for payment), and Other Tests - one test per line (21)
- Specimen Collection:** Time (24 hr) (19) and Date (yyyy-mm-dd) (20).
- Fecal Occult Blood Test (FOBT) (check one):** FOBT (non COC) or ColonCancerCheck FOBT (COC) (no other test can be ordered on this form).
- Footer:** A "Print" button and fields for Clinician/Practitioner Signature (22) and Date (23).

LEGEND

- 1 Submitting provider's name and address
- 2 Submitting provider's billing number
- 3 Pertinent clinical information
- 4 "Copy to" provider's full name and address
- 5 Phone number where submitting provider(s) can be reached
- 6 Date of service
- 7 Patient's current health card number
- 8 Patient's current version code
- 9 Patient's sex
- 10 Patient's date of birth (yyyy-mm-dd)
- 11 Patient's phone number
- 12 patient's last name
- 13 Patient's first and middle names
- 14 Patient's address
- 15 Test ordered (indicate fasting vs random where required)
- 16 Indicate source
- 17 Indicate whether PSA or Vit. D is insured or uninsured
- 18 Time and date of last dose from therapeutic drugs
- 19 Time of collection (24 hour clock)
- 20 Date of collection (yyyy-mm-dd)
- 21 Other tests (ICL, referred out)
- 22 Signature of submitting provider
- 23 Date signed