

Date received yyyy / mm / dd	PHOL No.
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General Test Requisition

ALL Sections of this Form MUST be Completed

<p>1 - Submitter</p> <p>Courier Code</p> <p>Provide Return Address:</p> <p>Name Address City & Province Postal Code</p>	<p>2 - Patient Information</p> <table border="1"> <tr> <td>Health No.</td> <td>Sex</td> <td>Date of Birth: yyyy / mm / dd</td> </tr> <tr> <td>Medical Record No.</td> <td></td> <td></td> </tr> <tr> <td>Patient's Last Name (per OHIP card)</td> <td colspan="2">First Name (per OHIP card)</td> </tr> <tr> <td colspan="3">Patient Address</td> </tr> <tr> <td>Postal Code</td> <td colspan="2">Patient Phone No.</td> </tr> </table>	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.	
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Patient's Last Name (per OHIP card)	First Name (per OHIP card)															
Patient Address																
Postal Code	Patient Phone No.															
<p>Clinician Initial / Surname and OHIP / CPSO Number</p> <p>Tel: _____ Fax: _____</p>	<p>Submitter Lab No.</p> <p>Public Health Unit Outbreak No.</p>															
<p>cc Doctor Information</p> <p>Name: _____ Tel: _____ Lab/Clinic Name: _____ Fax: _____ CPSO #: _____ Address: _____ Postal Code: _____</p>	<p>Public Health Investigator Information</p> <p>Name: _____ Health Unit: _____ Tel: _____ Fax: _____</p>															
<p>3 - Test(s) Requested (Please see descriptions on reverse)</p> <p>Test: Enter test descriptions below</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Hepatitis Serology</p> <p>See Tests Requested box</p>															
<p>4 - Specimen Type and Site</p> <p><input type="checkbox"/> blood / serum <input type="checkbox"/> faeces <input type="checkbox"/> nasopharyngeal <input type="checkbox"/> sputum <input type="checkbox"/> urine <input type="checkbox"/> vaginal smear <input type="checkbox"/> urethral <input type="checkbox"/> cervix <input type="checkbox"/> BAL <input type="checkbox"/> other - (specify) _____</p>	<p>Patient Setting</p> <p><input type="checkbox"/> physician office/clinic <input type="checkbox"/> ER (not admitted) <input type="checkbox"/> inpatient (ward) <input type="checkbox"/> inpatient (ICU) <input type="checkbox"/> institution</p>															
<p>5 - Reason for Test</p> <p><input type="checkbox"/> diagnostic <input type="checkbox"/> immune status Date Collected: _____ <input type="checkbox"/> needle stick <input type="checkbox"/> follow-up yyyy / mm / dd <input type="checkbox"/> prenatal <input type="checkbox"/> chronic condition Onset Date: _____ <input type="checkbox"/> immunocompromised yyyy / mm / dd <input type="checkbox"/> post-mortem <input type="checkbox"/> other - (specify) _____</p>	<p>Clinical Information</p> <p><input type="checkbox"/> fever <input type="checkbox"/> gastroenteritis <input type="checkbox"/> respiratory symptoms <input type="checkbox"/> STI <input type="checkbox"/> headache / stiff neck <input type="checkbox"/> vesicular rash <input type="checkbox"/> pregnant <input type="checkbox"/> encephalitis / meningitis <input type="checkbox"/> maculopapular rash <input type="checkbox"/> jaundice <input type="checkbox"/> other - (specify) _____ <input type="checkbox"/> influenza high risk - (specify) _____ <input type="checkbox"/> recent travel - (specify location) _____</p>															