Public Health Ontario | Santé publique Ontario
PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

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:

Name
Address
City & Province
Postal Code

Clinician Initial / Surname and OHIP / CPSO Number

Tel: _____ Fax: _____

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. PEEL-2019-001		

cc Doctor Information

Name: Dr. Laura Bourns Tel: 905-799-7700
Lab/Clinic Name: Peel Public Health Fax: 905-565-1456
CPSO #: 92990
Address: 7120 Hurontario St, PO Box 667 RPO Streetsville Postal Code: L5M2C1

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 acute infection
Hepatitis B immune status
Hepatitis C screen
HIV screen
-Only one tube of blood is required by the PHO Laboratory to perform all of the above tests.
-A separate HIV requisition is not required for this investigation per PHO Laboratory.

Hepatitis Serology

See Tests Requested box

4 - Specimen Type and Site

- ☑ blood / serum
- ☐ faeces
- ☐ nasopharyngeal
- ☐ sputum
- ☐ urine
- ☐ vaginal smear
- ☐ urethral
- ☐ cervix
- ☐ BAL
- ☐ other - *(specify)* _____

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 - *(specify)* PEEL-2019-001

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 - *(specify)* _____
- ☐ influenza high risk - *(specify)* _____
- ☐ recent travel - *(specify location)* _____

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
Agency for Health Protection and Promotion
Agence de protection et de promotion de la santé