

TESTING AIDS

AIDS ACTION NOW!

MAY 1989

LABORATORY NAME AND ADDRESS _____ Laboratory Number _____

OHIP Number _____ Subscriber's Last Name (Please print or type) _____ Initials _____

Patient's First Name (Print) _____ Patient's Birth Date Day _____ Month _____ Year _____ Patient's Sex M _____ F _____ Laboratory Accounting Number _____

Referring Lab Number _____ Service Date D _____ M _____ Y _____ Patient's Phone No. _____ Subscriber's Address (Print or type) _____ Town/City _____ Postal Code _____

Requisitioning Physician's Name _____ Requisitioning Physician's No. _____ Patient's Name _____

Clinical Problems, Medication etc. (optional) _____

X	Biochemistry	LAB CODE	OHIP CODE	X	Hematology	LAB CODE	OHIP CODE	Other tests, one per line (please type or print and use terminology of the OHIP Schedule of Benefits)	LAB CODE	OHIP CODE	NO. OF SER.
	Bilirubin, total			<input checked="" type="checkbox"/>	Blood Film Exam						
	Chloride			<input checked="" type="checkbox"/>	Hemoglobin						
	Cholesterol			<input checked="" type="checkbox"/>	W.B.C. count						
	Creatinine				Prothromb. time						
	Glucose			<input checked="" type="checkbox"/>	Sediment rate						
	Phosphatase Alk.			<input checked="" type="checkbox"/>	Hematocrit						
	Potassium				Immunology						
	SGOT				Heterophile antibodies screen						
	Sodium				Rubella titre						
	T.3 Uptake				Pregnancy test						
	T.4 Total				Prenatal ABG, RhD, antibody screen (type and ident. if positive)						
	Triglycerides				Repeat Prenatal antibodies						
	Urea Nitrogen (BUN)				VDRL						
	Uric Acid				Microbiology						
	Urinalysis R&M				Sensitivities if warranted						
					Cervical, vaginal						
					Sputum						
					Throat						
					Urine						
					Stool culture						
					Stool for Ova and Parasites						
					other swabs						

LABORATORY SERVICES REQUISITION AND OHIP CLAIM

Ministry of Health Ontario

1. OHIP Copy
2. Laboratory Copy
3. Physician's Copy

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

REQUISITIONING PHYSICIAN'S SIGNATURE _____ DATE _____

TOTAL FEE _____

I CERTIFY THIS TO BE A TRUE STATEMENT OF SERVICES PROVIDED AS REQUISITIONED. SIGNATURE FOR LABORATORY. (Medical Director if additional tests performed).

A Lab service requisition form: a familiar sight for people getting tested in Ontario

INSIDE:

HIV RELATED TESTS

CALCULATING YOUR ABSOLUTE T4 COUNT

WOMEN AND TESTING AIDS

ANONYMOUS TESTING

AIDS ACTION NOW!
OUT ELEMENT