



**PATHOLOGY LABORATORIES  
TEST REFERRAL REQUISITION**

Room A3-101, University Hospital  
339 Windermere Road, London, Ontario  
Telephone: (519) 685-8500 extension 32956  
Facsimile: (519) 663-2930

PIN \_\_\_\_\_ UNIT: \_\_\_\_\_ ROOM: \_\_\_\_\_  
NAME: \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
SEX \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ YYYY/MM/DD \_\_\_\_\_ AGE: \_\_\_\_\_  
OHC#: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_

**1. TEST REQUESTED**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. SAMPLE REQUIRED**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. CLINICAL INDICATIONS** (Requests will not be processed without history.)

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\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAILURE TO COMPLETE REQUISITION WILL RESULT IN DELAYS**

Referring Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Date of Request: (YYYY/MM/DD) \_\_\_\_\_  
Name of Referral Laboratory: \_\_\_\_\_

**If the referral laboratory is not in Ontario a completed copy of the form (# 1442-84) "Prior Approval Application for Full Payment of Insured Out-of-Country Health Services" must accompany this request. This form is available on the MoHLTC website [http://www.health.gov.on.ca/english/public/forms/form\\_menus/ohip\\_fm.html](http://www.health.gov.on.ca/english/public/forms/form_menus/ohip_fm.html)**