

# Prenatal Screening Requisition

Date received <i>yyyy / mm / dd</i>	OPHL No.
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### 1 - Submitter

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Clinician Name and ID Number	
Tel:	Fax:

### 2 - Patient Information

Health No. / HRN	Sex	Date of Birth: <i>yyyy / mm / dd</i>
Patient's Last Name (per OHIP card)		First Name (per OHIP card)
Patient Address		
Submitter Lab No.		

### 3 - Test(s) Requested

(Please check appropriate boxes)

Hepatitis B Surface Antigen  
 Rubella      Rubella done at other laboratory  
 Syphilis  
 HIV

Two full red top or SST tubes are sufficient for all tests  
 HIV testing can also be ordered separately using the HIV serology requisition or at any designated anonymous test site.  
 For any other tests please use the appropriate Public Health Laboratory test requisition and submit a separate specimen.

### Laboratory Results

For laboratory use only