



HCN: _____
 Province/Territory: _____ Expiry: YYYY / MON / DD
 Name: _____ First Middle Surname
 Date of Birth: YYYY / MON / DD Sex: M F UN
 Mailing Address: _____
 City: _____
 Province/Territory: _____ Postal Code: _____
 Telephone: (Indicate Preferred) Home () - - - -
 Cell () - - - - Work () - - - -

Laboratory Test Special Authorization

Ordering Provider's Name _____ Clinic Name: _____ Mailing Address _____ City: _____ Province/Territory: _____ Postal Code: _____ Phone: () - - - - Fax: () - - - - Signature: _____ Date: <u>YYYY / MON / DD</u>	Clinic Stamp: (include fax, provider and mnemonics) _____ Ordering Provider's Meditech Mnemonic: _____ EMR Clinic Mnemonic: _____ COPY TO PROVIDER _____
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Please indicate Laboratory Service area:

<input checked="" type="checkbox"/>	Laboratory Division	Laboratory Professional	Fax Number
<input checked="" type="checkbox"/>	Clinical Biochemistry	Biochemist on-call 697-2306	777-2442
<input type="checkbox"/>	Hematology	Hematopathologist, 777-6550 or see call schedule	777-8494
<input type="checkbox"/>	Public Health and Microbiology	Microbiologist on Call, contact switchboard (777-6300)	777-6362
<input type="checkbox"/>	Molecular Genetics	Molecular Geneticist, 570-1088, 777-2968	777-4792
<input type="checkbox"/>	Cytogenetics	Cytogeneticist, 777-4090, 777-2968	777-4792

*This form can be completed electronically, printed and then faxed. If completing by hand, please be sure to write legibly.
 This form is used for special authorization of laboratory tests, for out-of-province referral, restricted access tests, or for exception to the minimal retest interval.*

Test(s) to be Performed	Sample Type

Special Protocols (Based on consultation with Laboratory Professional)

Rationale for Test Request: (Please indicate how the result will affect a patient management decision)

Is this an urgent request? Yes No If yes, has the appropriate Laboratory Professional been notified? Yes No
 Anticipated collection date: YYYY / MON / DD or
 For collected samples: Collection Date: YYYY / MON / DD Collection Time: _____ Laboratory Specimen Number? _____
 Was test pre-approved? Yes No If yes, by whom: _____

Laboratory Professional Authorizing:

Name: _____ Signature: _____ Date: YYYY / MON / DD