CLIENT INFORMATION FORM

New: ☐ **Change**: ☐

Name: _____

MOHLTC Billing #: _____

Address: _____

Specialty: _____

OFFICE CONTACT

Contact: _____

Phone #: _____

Fax #: _____

Private Phone #: _____

Email Address: _____

OFFICE HOURS (hh:mm)			**Lunch Hour (hh:mm)**	
Sunday:	from: _____	to: _____	from: _____	to: _____
Monday:	from: _____	to: _____	from: _____	to: _____
Tuesday:	from: _____	to: _____	from: _____	to: _____
Wednesday:	from: _____	to: _____	from: _____	to: _____
Thursday:	from: _____	to: _____	from: _____	to: _____
Friday:	from: _____	to: _____	from: _____	to: _____
Saturday:	from: _____	to: _____	from: _____	to: _____

AFTER HOURS

Phone #: _____ **Description:** _____

Beeper #: _____

Cell Phone #: _____

Home #: _____

BACKUP COVERAGE

Backup Physician #: _____

Name: _____ **Phone #:** _____

AFFILIATION

Hospital Affiliation: _____ **Phone #:** _____

Other Affiliation: _____ **Phone #:** _____

Special Handling (please attach letter of authorization) Patient specific and/or result range specific

_____

_____

_____

Forward to LifeLabs via the local LifeLabs courier or fax to 905-795-9891