					ATHOLOGY REQUISITION  Laboratory Use Only					
Clinician/Practitioner Billing Number   Patient Chart Number   Patient Felephone N										
Clinician/Practitioner Phone Number   Patient Chart Number   Patient Chart Number   Patient Chart Number   Province   Other Province's Registration Number   Patient Chart Number   Province   Other Province's Registration Number   Patient Telephone Number   Province   Other Province's Registration Number   Patient Telephone Number   Patient T	amo	Requesting Clinician/Pra	ctitioner							
Health Card Number (HCN)	ille				Clinician/Practitioner Phone Number					Patient Chart Number
Inician/Practitioner Billing Number  Province Other Province's Registration Number  Patient Last Name (as per Health Card)  Patient First & Middle Name (as per Health Card)  Patient First & Middle Name (as per Health Card)  Patient First & Middle Name (as per Health Card)  Patient First & Middle Name (as per Health Card)  Patient Address (including postal cade)  Date of Clinical Procedure  Patient Address (including postal cade)  Date of Clinical Procedure  Patient Address (including postal cade)  Date of Clinical Procedure  Clinical Data (diagnosis or differential diagnosis)  B   Date of Clinical Procedure   Immunofluorescence   I	ddress				Health Card Number (HCN) Version Conder					Date of Birth
Patient Last Name (as per Health Card)  Patient Address (including postal code)  Patient First & Middle Name (as per Health Card)  Patient First & Middle Name (as per Health Card)  Patient Address (including postal code)  Patient First & Middle Name (as per Health Card)  Patient Address (including postal code)  Patient Add						iu Number (rich)		Version		YYYY / MO / D
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Anatomic Site & Procedure  Billing #   Date of Clinical Procedure   Procedure	py to Cli	nician(s)/Practitioner(s) (fill in all	fields)		Patient Last Name (as per Health Card)					
Anatomic Site & Procedure    Patient Address (including postal code)	me	Billing #								
Patient Address (including postal code)    Date of Clinical Procedure	ddress	dress			rauent riist & iviluule ivaille (us per neultri Curu)					
Date of Clinical Procedure WYYY   MO   DA    Date of Clinical Procedure   Clinical Data (diagnosis or differential diagnosis)    A					Patient Address (including postal code)					
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Excision	aui ess				Date of Cl	inical Procedure	YYYY /	MO / DA	A	
Shave   Curettage   Re-excision   Alopecia	ecimen	Anatomic Site & Procedure			1			Clinical E	Data (diagnosis	s or differential diagnosis)
Re-excision   Alopecia			_	=		Immunofluo	rescence			
B   Excision   Punch   Immunofluorescence	A			=	_					
Re-excision   Alopecia   Immunofluorescence   C   Shave   Curettage   Re-excision   Alopecia   Immunofluorescence   C   Re-excision   Alopecia   Immunofluorescence   Immunofluo						Immunofluo	rescence			
Excision   Punch   Immunofluorescence   Shave   Curettage   Re-excision   Alopecia   Punch   Immunofluorescence   Punch   Immunofluorescence   Punch   Immunofluorescence   Punch   Immunofluorescence   Punch   Immunofluorescence   Punch   Immunofluorescence   Punch   Punch   Immunofluorescence   Punch   Punc	В		Shave	Cu	ırettage	_				
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Shave				=	_					
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Re-excision	E		=	=		Immunofluo	rescence			
Shave			_	=	_					
Re-excision   Alopecia	_		Excision	Pu	ınch	Immunofluo	rescence			
G   Excision   Punch   Immunofluorescence   Shave   Curettage   Re-excision   Alopecia   Immunofluorescence   Punch   Immunofluorescence   Re-excision   Alopecia   Immunofluorescence   Immunofluores	F		_		•					
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H Curettage Re-excision Alopecia  tal number of containers submitted with this requisition (maximum 8) Physician/Practitioner Signature			Re-excision	Ale	opecia					
Re-excision Alopecia  tal number of containers submitted with this requisition (maximum 8) Physician/Practitioner Signature			=	_		Immunofluo	rescence			
tal number of containers submitted with this requisition (maximum 8) Physician/Practitioner Signature	н		_		_					
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	tal numbe	er of containers submitted with t	his requisition (ma	ximum 8,	)	Physician/Prac	titioner Signat	ure		
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