DERMATOPATHOLOGY REQUISITION

CLEAR FORM

LifeLabs® Medical Laboratory Services

Requesting Clinician/Practitioner

Name

Address

Clinician/Practitioner Billing Number

Laboratory Use Only

Clinician/Practitioner Phone Number | Patient Chart Number

Health Card Number (HCN) | Version | Gender ☐ M ☐ F | Date of Birth YYYY / MO / DA

Province | Other Province's Registration Number | Patient Telephone Number

Copy to Clinician(s)/Practitioner(s) *(fill in all fields)*

Name Billing #

Address

Name Billing #

Address

Patient Last Name *(as per Health Card)*

Patient First & Middle Name *(as per Health Card)*

Patient Address *(including postal code)*

Date of Clinical Procedure YYYY / MO / DA

Specimen	Anatomic Site & Procedure				Clinical Data (diagnosis or differential diagnosis)
A		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
B		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
C		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
D		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
E		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
F		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
G		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	
H		☐ Excision ☐ Shave ☐ Re-excision	☐ Punch ☐ Curettage ☐ Alopecia	☐ Immunofluorescence	

Total number of containers submitted with this requisition *(maximum 8)* _____ **Physician/Practitioner Signature** _____

Laboratory Use Only:

PRINT

For Inquiries, contact LifeLabs Customer Care Centre – Toll Free: 877-849-3637 or GTA: 416-675-3637