Healthcare Provider information update

Dear Healthcare Provider,

In order to deliver your reports and communicate results when generated, we ask that the enclosed form be completed and returned to us by fax, to **(905) 565 9316**. Once received, the information will be used to update our client records.

Your prompt attention is appreciated to avoid any delay with result delivery.

Sincerely,

LifeLabs Client File Team

Instructions to complete

1. Fill in the form
2. Fax the completed form from your office fax number to LifeLabs at (905) 565-9316
3. Use NA (not applicable) in the fields that do not apply

Healthcare Provider information update

☐ NEW request	☐ CHANGE see below	Date of Request:	

The request is for					
☐ Physician	☐ RN-EC	☐ RM (Registered Midwife)	☐ Clinic	☐ Nursing/Retirement Home	☐ Contract

Speciality:	

If this is a change request, please provide the previous address below:

Current Address					
Client Name:					
MOH Billing Number:		Report to Attn (PRINT):		Billing Number:	
Address (PRINT):					
City:		Province:		Postal Code:	
Office Phone:		Office Fax:			

After-Hours Contact Information			
Home Phone:		Cellular Phone:	
Pager:		Other Number: (Please indicate type)	

Special Instructions to follow After-Hours: Please call cellular phone for urgent matters		
Hours of Operation:	HOURS	LUNCH
Monday	to	to
Tuesday	to	to
Wednesday	to	to
Thursday	to	to
Friday	to	to
Saturday	to	to
Sunday	to	to

This form should be signed by the physician or authorized personnel. Please return this completed signed form as soon as possible to fax number **(905) 565-9316.**

_____ **Authorized Signature**

_____ **Print Name**

_____ **Date**