



## SMARTVascular Dx Private Pay Test Requisition

PRINT IN ALL CAPITAL LETTERS. One (1	<u>J lesi kequisilion per pulleni.</u> IMi o			
Report-to Client:	Physician OHIP # (ON)			
Report-to Client:	Physician MSP # (BC)			
Ordering Physician Name:			LifeLabs	
			Demographic Label	
			-	
Ordering Physician Address			_	
and Contact Information:				
	Tel:		LifeLabs	
	Fax:		Billing Label (ON)	
			LifeLabs	
			Physician Summary Label (BC)	
Copy to Physician Address				
and Contact Information:				
	Tel:		LifeLabs	
	Fax:		Test List Label	
Bill to:	Bill TYPE "PATIENT PAYS"			
Bill IO.	(patient to pay at time of servi	ce)		
	(pariere to pay at time of our	,		
PATIENT INFORMATION				
Patient Last Name Patient First Name				
Date of Birth (YYYYMMDD) – ON; (DDMMYYYY) - BC Age Sex 🗆 Male Telephone Number				
Patient Address				
	TECT DE	OUESTED		
TEST REQUESTED           Test Code (ON)         Mnemonic (BC)				
☑ SMARTVascular Dx		5490 SMTVD		
PATIENT HISTORY & RISK FACTORS (must be completed by Physician or Patient)				
Height:cm				
	Weiaht: ka			
V N	Weight:kg	N		
YN	Y	N	n	
🗆 🗆 Smoker (Last 30 Days)	Y	Diabetes Medication		
<ul> <li>Smoker (Last 30 Days)</li> <li>Diabetic</li> </ul>	Y		ication	
<ul> <li>Smoker (Last 30 Days)</li> <li>Diabetic</li> </ul>	Y □ □ t/Sibling/Child)	<ul> <li>Diabetes Medication</li> <li>Lipid lowering medication</li> </ul>	ication 0/90 mmHg)	
<ul> <li>Smoker (Last 30 Days)</li> <li>Diabetic</li> <li>Family Hx of MI (Parent)</li> </ul>	Y t/Sibling/Child)	<ul> <li>Diabetes Medicatio</li> <li>Lipid lowering med</li> <li>Hypertension (&gt; 14</li> <li>Blood Pressure med</li> </ul>	ication 0/90 mmHg)	
<ul> <li>Smoker (Last 30 Days)</li> <li>Diabetic</li> <li>Family Hx of MI (Parent)</li> </ul>	Y t/Sibling/Child)	<ul> <li>Diabetes Medication</li> <li>Lipid lowering medication</li> <li>Hypertension (&gt; 14</li> </ul>	ication 0/90 mmHg)	
<ul> <li>Smoker (Last 30 Days)</li> <li>Diabetic</li> <li>Family Hx of MI (Parent</li> <li>Patient Hx of MI**</li> </ul>	Y t/Sibling/Child)	<ul> <li>Diabetes Medicatio</li> <li>Lipid lowering med</li> <li>Hypertension (&gt; 14</li> <li>Blood Pressure med</li> </ul>	ication 0/90 mmHg) dication	
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<ul> <li>Smoker (Last 30 Days)</li> <li>Diabetic</li> <li>Family Hx of MI (Parent</li> <li>Patient Hx of MI**</li> </ul>	Y t/Sibling/Child) PHYSICIAN	<ul> <li>Diabetes Medicatio</li> <li>Lipid lowering med</li> <li>Hypertension (≥ 14</li> <li>Blood Pressure med</li> </ul>	ication D/90 mmHg) dication	
Smoker (Last 30 Days)         Diabetic         Family Hx of MI (Parent         Patient Hx of MI**         X         Please check box if you do NOT	Y t/Sibling/Child) PHYSICIAN	<ul> <li>□ Diabetes Medicatia</li> <li>□ Lipid lowering med</li> <li>□ Hypertension (≥ 14</li> <li>□ Blood Pressure med</li> <li>■ SIGNATURE</li> </ul>	ication D/90 mmHg) dication Date: control purposes.	
Smoker (Last 30 Days)         Diabetic         Family Hx of MI (Parent)         Patient Hx of MI**         X         Please check box if you do NOT         SPECIMEN	Y t/Sibling/Child) PHYSICIAN want your de-identified sample use INFORMATION(must be com	<ul> <li>□ Diabetes Medicatia</li> <li>□ Lipid lowering med</li> <li>□ Hypertension (≥ 14</li> <li>□ Blood Pressure med</li> </ul> I SIGNATURE ed for research and quality pleted by LifeLabs star	ication D/90 mmHg) dication Date: control purposes. if or collection site)	
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Smoker (Last 30 Days)         Diabetic         Family Hx of MI (Parent)         Patient Hx of MI**         X         Please check box if you do NOT         SPECIMEN	Y t/Sibling/Child)  PHYSICIAN  want your de-identified sample us INFORMATION(must be com Time Blood Collected:	<ul> <li>□ Diabetes Medicatia</li> <li>□ Lipid lowering med</li> <li>□ Hypertension (≥ 14</li> <li>□ Blood Pressure med</li> </ul> I SIGNATURE ed for research and quality pleted by LifeLabs state □ FASTING	ication D/90 mmHg) dication Date: control purposes. if or collection site)	
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Smoker (Last 30 Days)         Diabetic         Family Hx of MI (Parent)         Patient Hx of MI**         Please check box if you do NOT         SPECIMEN         Date Blood Collected:         (DDMMYYYY)	Y t/Sibling/Child) PHYSICIAN want your de-identified sample use INFORMATION(must be com Time Blood Collected: (HH:MM)	□ Diabetes Medication         □ Lipid lowering medication         □ Hypertension (≥ 14         □ Blood Pressure medication         I SIGNATURE         ed for research and quality         pleted by LifeLabs state         □ FASTING         □ NON-FASTING	ication D/90 mmHg) dication Date: control purposes. if or collection site) hours prior to test	

The minimum amount of patient information is collected, used, and disclosed for provision of the service requested in accordance with the applicable privacy law. Samples may be referred to a testing laborato in another province or U.S.A. This information is considered confidentia Unauthorized use and disclosure are prohibited.