LifeLabs®

Healthcare Provider Information Form

Province					
☐ ON	☐ BC				
Type of Request					
☐ New	☐ Change	Date of Request:			
The request is for					
☐ Physician	☐ RN-EC	☐ RM (Registered Midwife)	☐ Clinic	☐ Nursing/Retirement Home	☐ Other
Specialty:					
Current Address					
Client Name:					
MOH Billing Number:					
Address:					
City:		Province:		Postal Code:	
Office Phone:		Office Fax:			
If this is a change request, please provide the previous address below:					
Mode of Report Delivery					
☐ Fax	☐ EMR	☐ Launchpad			
After-Hours Contact Information-Must provide at least one					
Home Phone:		Cellular Phone:			
Pager:		Other Number: (Indicate Type)			
Authorized Signature:					
Print Name:					
Date:					
This form should be signed by the physician or authorized personnel. Please fax this form to: BC- 604-507-5225 ON- 1-866-362-5860					