IsoPSA Requisition Form

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CLEAR FORM

Ordering healthcare provider information	Name:		**LifeLabs use only**
	Billing #:	Institution:	
	Phone:	Fax:	
	Email:		
	Address:		
Ordering healthcare provider signature	Please sign here:		
Copy to	Name:		
	Billing #:		
	Address:		
Patient information	First name:	Last name:	
	Phone:	Date of birth (YYYY/MM/DD): / / /	
	Address:		
	PHN or OHIP #:	Sex assigned at birth: ☐ Male ☐ Female	
	Email:		
Billing information	☐ Private-Pay (patient must pay at time of collection) ☐ Contract Contract/account number:		

☒ **IsoPSA**	ON - Test code: **1892**	BC - Mnemonic: **ISOPSA**
Date sample collected:	Time sample collected:	Phlebotomist:

Note: IsoPSA has been validated for patients age 50 years or older and who have a total PSA 4.0ng/mL. As part of the IsoPSA analysis, a total PSA test will be performed on the sample provided. If any of the parameters required to calculate the IsoPSA Index are outside of their range of quantification, the IsoPSA result will not be provided and only the total PSA result will be reported and billed.