Newfoundland Labrador

HCN: ---

Province/Territory: ____ Expiry: _____ _____ _____

DOB: _____/_____/_____ Sex: ❑ M ❑ F ❑ UN

Name: _____

Mailing Address: _____

City: _____ Prov: ____ Postal Code: _____

Telephone: (Indicate Preferred) ❑ Home _____

❑ Cell (____) ___ ___ ____ ❑ Work (____) ___ ___ ____

Laboratory Test Special Authorization

Ordering Provider's Name _____

Clinic Name: _____

Mailing Address _____

City: _____

Province/Territory: _____ Postal Code: _ _ _ _ _ _

Phone: (_ _ _) – _ _ _ – _ _ _ _ Fax: (_ _ _) – _ _ _ – _ _ _ _

Signature: _____ Date: YYYY / MON / DD

Clinic Stamp:(include fax, provider and mnemonics)

Ordering Provider's Meditech Mnemonic: _____

EMR Clinic Mnemonic: _____

COPY TO PROVIDER _____

Please indicate Laboratory Service area:

✔	Laboratory Division	Laboratory Professional	Fax Number
❑	Clinical Biochemistry	Biochemist on–call 697–2306	777–2442
❑	Hematology	Hematopathologist, 777–6550 or see call schedule	777–8494
❑	Public Health and Microbiology	Microbiologist on Call, contact switchboard (777–6300)	777–6362
❑	Molecular Genetics	Molecular Geneticist, 570–1088, 777–2968	777–4792
❑	Cytogenetics	Cytogeneticist, 777–4090, 777–2968	777–4792

This form can be completed electronically, printed and then faxed. If completing by hand, please be sure to write legibly.
This form is used for special authorization of laboratory tests, for out–of–province referral, restricted access tests, or for exception to the minimal retest interval.

Test(s) to be Performed	**Sample Type**

Special Protocols (Based on consultation with Laboratory Professional)

Rationale for Test Request: (Please indicate how the result will affect a patient management decision)

Is this an urgent request? ❑ Yes ❑ No If yes, has the appropriate Laboratory Professional been notified? ❑ Yes ❑ No

Anticipated collection date: YYYY / MON / DD **or**

For collected samples: Collection Date: YYYY / MON / DD Collection Time: _____ Laboratory Specimen Number? _____

Was test pre–approved? ❑ Yes ❑ No If yes, by whom: _____

Laboratory Professional Authorizing:

Name: _____ Signature: _____ Date: YYYY / MON / DD

W-REF-045

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