LABORATORY REQUISITION FORM

Patient Information

Full Name: _____ Gender: _____

Date of Birth (YYYY-MM-DD): _____ Health Card No.: _____

Address: _____

Phone Number: _____ Email: _____

Physician Information

Full Name: _____ License Number: _____

Clinic/Hospital: _____

Phone Number: _____ Email: _____

Sample Collection Details

Sample Type: _____ Collection Date/Time: _____

Collection Location: _____

Tests Requested

- ☐ **Complete Blood Count (CBC)**
- ☐ **Basic Metabolic Panel (BMP)**
- ☐ **Liver Function Tests (LFTs)**
- ☐ **Thyroid Stimulating Hormone (TSH)**
- ☐ **Hemoglobin A1c (HbA1c)**
- ☐ **Lipid Panel**
- ☐ **Urinalysis**
- ☐ **Coagulation Profile**
- ☐ **Vitamin D**

Relevant Clinical History, Symptoms, or Diagnosis (mandatory for certain tests):

Consent and Acknowledgement

I hereby authorize the laboratory to perform the requested tests and understand that the results will be communicated to the ordering physician. I acknowledge that the information provided is accurate to the best of my knowledge. I understand that the laboratory will handle my personal and health information in accordance with Canadian privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA).

PATIENT SIGNATURE

Signature: _____

PHYSICIAN SIGNATURE

Signature: _____

This Laboratory Requisition Form complies with applicable Canadian laws, regulations, and standards. The laboratory and healthcare providers are committed to protecting patient confidentiality and ensuring accurate test processing. By signing, the undersigned acknowledges understanding and acceptance of the procedures and privacy policies.