THE HOSPITAL FOR SICK CHILDREN

Paediatric Laboratory Medicine

**MOLECULAR HAEMATOPATHOLOGY LABORATORY**

555 University Avenue
Room 3603, Atrium
Toronto, ON, M5G 1X8, Canada

Tel: 416-813-7200
Fax: 416-813-5431

*Last Name:*

*First Name:*

*Date of Birth (DD/MM/YYYY):*

*Gender:* ☐ *Male* ☐ *Female*

*Address:*

***For Canada Only***

*Provincial Health Card #:* *Version:*

*Issuing Province:*

# MOLECULAR HAEMATOPATHOLOGY

**Referred-in Requisition**

## SPECIMEN

- Blood in EDTA (Lavender top tube) at room temperature (minimum 2 mL)

## SPECIMEN COLLECTION

| **DATE** (DD/MM/YYYY) | **TIME** (HH:MM) | **COLLECTED BY** |
|---|---|---|
| | | |

## DELIVERY OF SPECIMENS

Monday to Friday between 8:30 AM to 5:00 PM

**Address:**

The Hospital for Sick Children
Rapid Response Laboratory
170 Elizabeth Street, Room 3642
Toronto, ON, M5G 2G3, Canada

## CLINICAL INFORMATION

## TESTS

☐ Factor V Leiden

☐ JAK2

☐ Prothrombin

☐ Methylenetetrahydrofolate Reductase (MTHFR)

☐ TPMT Genotyping

☐ FLT-3 ITD

☐ Other: ____________________

## RESPONSIBLE / REFERRING PHYSICIAN

Name (print) ____________________

Address ____________________

____________________

____________________

Phone ____________________ Fax ____________________

Signature ____________________

## COPY OF REPORT TO:

Name (print) ____________________

Address ____________________

____________________

____________________

**FOR LABORATORY USE ONLY:**

**Y#** ____________________ **P#** ____________________

**Date received:** ____________________

**Technologist:** ____________________

**Comments:** ____________________

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# BILLING FORM

**How to complete the Billing Form:** *(Completion of Billing Form NOT required for patients with an Ontario Health Card Number.)*

- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

## Option 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: ____________________

Billing address of hospital, referring laboratory:

Name: ____________________

Address: ____________________

City: ____________________ Prov/State: __________

Postal/Zip Code: ____________________ Country: __________

Contact Name: ____________________

Contact Telephone #: ____________________

## Option 2: Interm Federal Health Program (IFHP)

**Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.**

UCI# ____________________

ICD code *(lab use only)*: ____________________

## Option 3: Complete to have Patient/Guardian billed directly:

*If you elect to have patient/guardian billed:*

- *Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.*
- *Please advise the patient/guardian to expect a bill from our laboratory.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

**Relation to patient** (check one): ☐ Patient ☐ Guardian/Parent

**Method of Payment** (check one): ☐ American Express ☐ MasterCard ☐ Visa

Name as it appears on credit card: ____________________

Credit card # : ____________________

Expiry date on credit card: ____________________

CVC#- found on back of card (Required): ____________________

**Mailing Address of Patient/Guardian** (if different from requisition):

Name: ____________________

Address: ____________________

____________________ Apt. #: __________

City: ____________________ Prov/State: __________

Postal/Zip Code: ____________________ Country: __________

**Additional Contact Information**

Patient's phone # with area code:

____________________

***- or -***

Guardian's phone # with area code:

____________________