SickKids
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

Patient Name:
Date of Birth (DD/MM/YYYY):
Sex Assigned at Birth: ○ *Male* ○ *Female* ○ *Unassigned*
Legal Sex (if different): ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Gender Identity: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Parent's Name:
Address:

For Canada Only
Health Card #:
Issuing Province:

Version

MOLECULAR HAEMATOPATHOLOGY

Referred-in Requisition

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

SPECIMEN

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

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#** _____ **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:

_____