Alberta Health Services

Calgary Laboratory Services ®

OPHTHALMIC PATHOLOGY CONSULTATION REQUISITION

* REQUIRED INFORMATION

PHYSICIAN TO ACT ON RESULTS:

* Last Name ______ * Full First Name ______

* Office Address (Location Code) for Report Delivery ______

Report to be ☐ PHONED ☐ FAXED to: ______ Number

* **TISSUE REMOVED BY:** ☐ **SAME PERSON/LOCATION AS ABOVE**

Last Name ______ Full First Name ______

Office Address (Location Code) for Report Delivery ______

* Affix addressograph imprint or patient label to **ALL PAGES** or clearly print patient's full name (last name, full first name), date of birth, gender, Personal Health Number, and Regional Health Record Number.

* DATE / TIME COLLECTED:

Y Y Y Y / M M M / D D

H H : M M

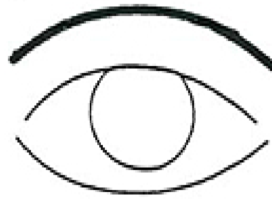
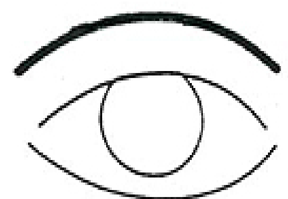
ACCESSION NUMBER (Lab Use Only)

ADDITIONAL COPIES TO:

1) * Last Name ______ * Full First Name ______ * Office Address for Report Delivery / Location Code ______

2) * Last Name ______ * Full First Name ______ * Office Address for Report Delivery / Location Code ______

History, Clinical Data, Operative Findings

OD	OS
	

Previous Biopsies

Clinical Diagnosis

Laboratory Information Centre: 403-770-3600 www.calgarylabservices.com

CLS Form# REQ9033AP 20111114