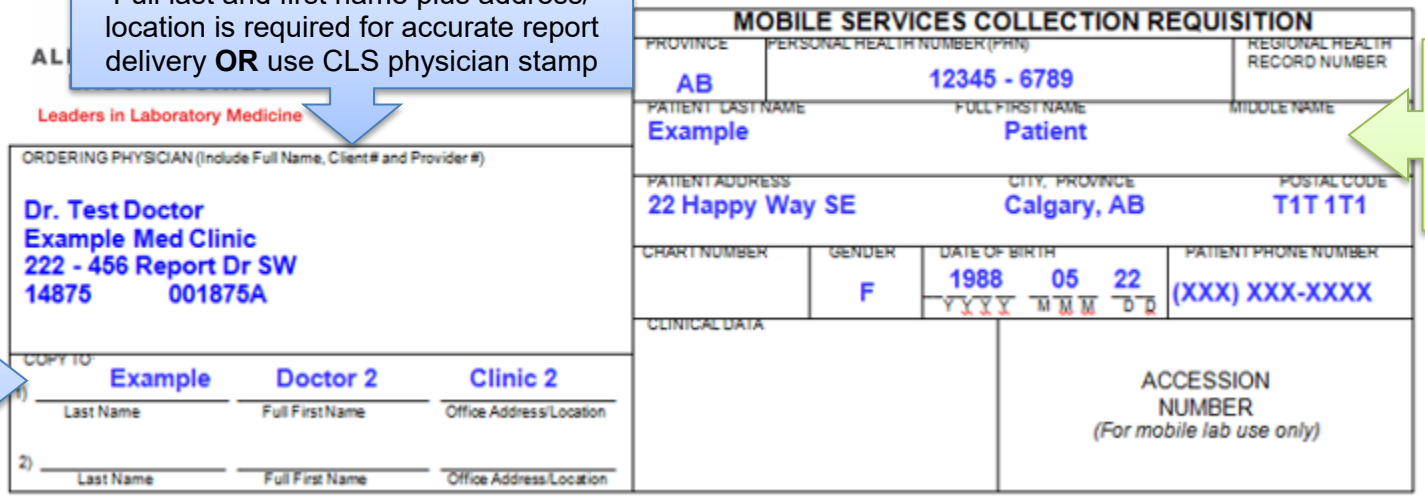
ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Requisition Requirements – Mobile Services Collection

Ordering Physician
Full last and first name plus address/ location is required for accurate report delivery **OR** use CLS physician stamp



MOBILE SERVICES COLLECTION REQUISITION

ORDERING PHYSICIAN (Include Full Name, Client # and Provider #)
Dr. Test Doctor
Example Med Clinic
222 - 456 Report Dr SW
14875 001875A

PROVINCE: AB
PERSONAL HEALTH NUMBER (PHN): 12345 - 6789
REGIONAL HEALTH RECORD NUMBER:
PATIENT LAST NAME: Example
FULL FIRST NAME: Patient
MIDDLE NAME:
PATIENT ADDRESS: 22 Happy Way SE
CITY, PROVINCE: Calgary, AB
POSTAL CODE: T1T 1T1
CHART NUMBER:
GENDER: F
DATE OF BIRTH: 1988 05 22 (YYYY MMM DD)
PATIENT PHONE NUMBER: (XXX) XXX-XXXX
CLINICAL DATA:

COPY TO
1) Example (Last Name) Doctor 2 (Full First Name) Clinic 2 (Office Address/Location)
2) (Last Name) (Full First Name) (Office Address/Location)

ACCESSION NUMBER
(For mobile lab use only)

Patient Information
Complete all fields to ensure accurate patient identification and registration

If **Copy To** reports are required, provide full last and first name, plus address/location for accurate report delivery

Patient Eligibility Requirements

Select one of the following eligibility criteria for the patient to receive mobile services:

- ❑ The patient has had a recent hospitalization and/or surgery that temporarily restrict their travel outside th (maximum 4 weeks).
  Specify reason: _____
  Hospital discharge date: (yyyy-mmm-dd) _____
- ❑ The patient has an ongoing medical restriction and is unable to attend appointments or other activities o
  Specify Condition impeding mobility: _____
- ❑ The patient resides in a secured or safe living environment e.g. Remand Centre, Dementia Unit.

Patient Eligibility Requirements
One of the defined criteria must be selected for a patient to be eligible for Mobile services

Scheduling Requirements

Requested Start Week of: _____ (Service date will be determined by patient location/address)

Select testing frequency and mobile order history:

Frequency	Maximum Duration
❑ Once only	Once
❑ 2X /Week	2 weeks (M/Th or Tu/F)
❑ 3X /Week	2 weeks (M/W/F)
❑ Weekly	3 months
❑ Every 2 Weeks	6 months
❑ Monthly	1 year
❑ Every 3 Months	1 year
For other frequencies consult mobile services.	

If this patient has an existing Mobile order check one of the following:

- ❑ Addition to next scheduled collection
- ❑ Replacement of all existing orders
- ❑ Schedule extra collection: _____

Scheduling Requirements
Indicate frequency/duration and if the patient has an existing mobile order