ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

ProvLab Add On Test Fax

Written documentation of add-on laboratory tests is required. Processing will not occur until receipt of faxed authorization.

Lab Use (Testing area)		Lab Use (Data Entry function)
☐ **CALGARY ProvLab** 3030 Hospital Dr NW Calgary, Alberta, T2N 4W4 Tel: (403) 944-1200 **Fax:**	☐ **EDMONTON ProvLab** 8440-112 Street Edmonton, Alberta, T6G 2J2 Tel: (780) 407-7121 **Fax:**	**Orderable:** **Order Comment: ADTEST**

Lab Use only

Complete this section.

Requester Full Name (PRINT): MOC/VOC? ☐ YES ☐ NO (Last) (First) (Initial)		Date and time of add-on test: dd mon yyyy time (hh:mm)
Ordering Physician/Practitioner:	Physician Code:	Requester Phone:
Ordering Address / Location:		Requester Fax:
Patient Name (PRINT): (Last) (First) (Initial)		☐ PHN: OR ☐ Other Unique Identifier (specify):
Sample Accession Number:		Lab staff name/initials:
Sample Type	Sample Source	Date and time of original sample collected: dd mon yyyy time (hh:mm)
Test(s) to be added:	☐ Routine ☐ Priority ☐ Stat	☐ Add-on test communicated via:

REQUESTOR

Complete this section. Fax to the lab indicated above:

☐ I have verified that the patient name and PHN/other unique identifier are correct as written above.
(NOTE: Contact the lab if any information provided above is incorrect)

Check ONLY ONE response below:

☐ I have verified that the Ordering Physician /Practitioner information above is complete and request report to be sent there.

☐ I request the report for this add-on test to be sent to above location **AND** to another Physician/Practitioner as completed below (write legibly).

Physician/Practitioner Name:	Phone:
Physician/Practitioner Address /Location:	Fax:
☐ Requester's Signature:	Date and time: dd mon yyyy time (hh:mm)

LAB USE: Complete this section if add on tests cannot be performed for the following reasons:

☐ Insufficient sample quantity	☐ Test Cancelled by:
☐ Compromised sample quality	Tech (name and initials):
☐ Other:	