ALBERTA PRECISION LABORATORIES

Ophthalmic Pathology Requisition

Scanning Label or Accession # *(lab only)*

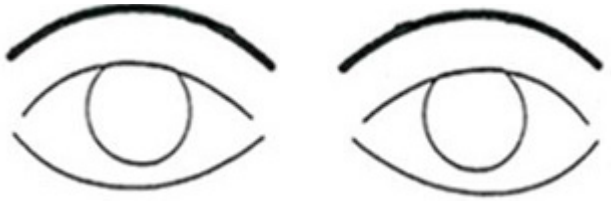
Order Date *(dd-Mon-yyyy)*			
Patient			
PHN Expiry: _____	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code
Provider(s)			
Authorizing Provider *(last, first, middle name)*	Address		
Clinic Name	Phone	CC Provider ID	CC Submitter ID
Copy to	Address	Phone	Clinic Name
Copy to	Address	Phone	Clinic Name
Collection	Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Sample(s) / Tissue(s)

ID	**Exact Anatomical Site** *(including laterally)*, **Organ of Origin, and Collection Procedure** *List all samples. Ensure sample labels match requisition.* *List all special handling, studies, and test requets with the sample.*	**Removed Time** *(hh:mm)*	**In Fixative Time** *(hh:mm)*

Clinical History

Right **Left**



Previous Biopsies