Client Information: Submit one specimen per test unless otherwise specified	
Referring Client: (Name and Address)	Date Sent: dd/mm/yyyy
Ordering Clinician's Name:	

Patient Demographics: Please complete all ** required fields or use a patient specimen label in the designated area (preferred)					
ICL Accession Number	*For ICL use only*				**or Place Specimen label here (preferred)**
**Collection Date/Time	Day	Month	Year	Time	
**Patient Name (Last, First)					
**Date of Birth	Day	Month	Year	Sex	
Provincial Health Insurance Number (PHIN)					
**Specimen # or Patient File #					

Order/Test Information:		
Specimen Type: Serum ☐ Plasma ☐ Whole Blood ☐ Urine ☐ Other: (Specify Source) _______________________________	24Hr Urine Volume(L): (if applicable) Hct: (if applicable) Timing: (if applicable)	** Specimen sent frozen: **Yes** ☐ **No** ☐
Order choice/ Test:	Additional Information:	