IMMUNOLOGY/HEMATOLOGY APPROVAL FOR TEST REFERRAL

Physicians: Please complete the following (this is an electronically fillable form) and forward to: psun@sharedhealthmb.ca and bmonnier@sharedhealthmb.ca or fax: 204-787-4030

Patient Name: _____

PHIN (if applicable): _____

CR# (if applicable): _____

DOB (mm/dd/yyyy): _____

Ordering Physician: _____

Physician Contact Info: Phone: _____ Fax: _____

Clinical suspicion/diagnosis: _____

Testing Requested: _____

What diagnostic/laboratory data supports the need for the testing requested: * _____

How will this test impact diagnosis? * _____

How will this test impact prognosis or treatment? * _____

How will the patient's treatment or course be affected if this test is not performed? * _____

*If additional space is required, please attach supporting documentation.

APPROVED: YES ☐ No ☐

Shared Health Signing Officer: _____ Date: _____