



**Application Form – New Requisition**

(Submit completed application and required documents to: [requisitions@phsa.ca](mailto:requisitions@phsa.ca))

**Section 1 Application Information**

Date and Requestor contact information	Application Date	Proposed Start Date
	Name	Title/Position
	Email	Phone No.

**Section 2 Facility Information**

Facility Information	Legal Name
	Address
	Organization
Medical Director	Name
	Email
	Phone

**Section 3 Requisition**

Requisition Information	Full title of Laboratory Requisition		
	Form Number	Version	
	Does this requisition replace or negate the need for an existing approved requisition?		Yes No
Header	<p><b>Note: A copy of the new requisition must accompany this application.</b></p> <p>If yes provide the title(s) and attach a copy of the form(s) being replaced</p>		
	Indicate if the requisition contains all the following elements:		
	Organization Name and/or Logo		Yes No
	Full Title of the requisition (Required)		Yes No
	BC Guideline reference statement	N/A	Yes No



Patient	Last Name, First Name (Required)		Yes	No	
	Date of Birth (Required)		Yes	No	
	Sex: Female, Male, X, Unknown (Required)		Yes	No	
	Provincial Health Number (PHN) (Required)		Yes	No	
	Address: Unit number, Street Name, Town/City, Postal Code		Yes	No	
	Telephone Number		Yes	No	
Practitioner	Referring Practitioner: Last Name, First Name (Required)		Yes	No	
	Referring Practitioner: MSP Number (Required)		Yes	No	
	Address: Unit number, Street Name, Town/City, Postal Code		Yes	No	
	Telephone Number		Yes	No	
	Copy to Practitioner: Last Name, First Name, MSP Number		Yes	No	
Tests	Diagnosis and/or relevant clinical history (Required)		Yes	No	
	Current medications including date/time of last dose		N/A	Yes	No
	Test selection including:	Indication of relevant BC Guidelines	N/A	Yes	No
		Collection Site	N/A	Yes	No
		Sample Type	N/A	Yes	No
Footer	Ordering practitioner signature and date (Required)		Yes	No	
	Specimen collection date and time (Required)		Yes	No	
	Specimen collector	N/A	Yes	No	
	Standard privacy statement (Required)		Yes	No	
	Requisition number and version (Required)		Yes	No	
Intended Use	Inpatient Testing Only	Outpatient Testing Only			
	Inpatient and Outpatient testing		Specialty Clinic		
	Provincial program (used by all sites)		Health Authority Specific		
	Tests are reimbursed via: ( select all that apply below )				
	MSP Funding	Global Funding	Program Funding	Private Pay	



**Section 4 Rationale**

	Describe in detail the rationale for this new requisition
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**Section 5 Stakeholder Consultation**

	List the stakeholders consulted in creation of the requisition											
	<table border="1"><thead><tr><th style="background-color: #d9ead3;">Name</th><th style="background-color: #d9ead3;">Title / Position</th><th style="background-color: #d9ead3;">Organization</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></tbody></table>	Name	Title / Position	Organization								
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