

 FlowLabs ADVANCED LABORATORY DIAGNOSTICS Laboratory Requisition Requisitioning Clinician/Practitioner Name _____ Address _____	Laboratory Use Only *Please book your appointment with Flowlabs <u>at least 3 weeks prior</u> to your follow up with your doctor.*		
	Clinician/Practitioner's Contact Number for Urgent Results _____		Service Date yyyy mm dd
CONO Registration Number _____	Health Number _____	Version _____	Sex ☐ M ☐ F
	Province _____	Other Provincial Registration Number _____	Date of Birth yyyy mm dd
Additional Clinical Information (e.g. diagnosis)	Patient's Last Name (as per OHIP Card) _____		
	Patient's First & Middle Names (as per OHIP Card) _____		
Copy to: Clinician/Practitioner Last Name _____ First Name _____	Patient's Address (including Postal Code) _____		
Address _____			

Male Infertility Investigation:

- ☐ Semen Analysis (count, motility & morphology, IgG, IgA)
☐ Post-Ejaculate Urine Cytology (identification of spermatozoa)
☐ DNA Integrity Assay/DFI
☐ Aneuploidy

NOTE: All clinicians who require test results must be listed on the requisition by the ordering clinician at the time of submission, as FlowLabs cannot alter a requisition. If a clinician is not listed, results will only be released after receipt of a patient-signed Release of Information authorizing disclosure.

FlowLabs offers both on-site collection and sample drop-off, **by appointment only**. Appointments must be booked through the FlowLabs website at www.flowlabs.ca and only after patient registration. Please arrive 5 minutes early; patients who arrive more than 10 minutes late may not be accommodated.

Patients must abstain from ejaculation for no fewer than 2 and no more than 5 days prior to semen collection. If collection is performed through intercourse, non-toxic condoms must be used.

For questions, contact info@flowlabs.ca or 416-581-0000; responses are provided within 1–2 business days. Payment for any non-OHIP-covered tests and for approved non-toxic condoms is completed during the registration and ordering process.

I hereby certify that the tests ordered are not for registered in- or out-patients of a hospital.

X _____
Clinician/Practitioner Signature

Date