**Please complete all applicable fields**

|  |  |
| --- | --- |
| **Department** | **Laboratory** |
| **Date of Visit** |  |
| **Time of Visit** |  |
| **Legal Name (First Middle Last)** |  |
| **Maiden/Other Names** |  |
| **Date of Birth (day/month/year)** |  |
| **Gender** |  |
| **Mother’s First Name** |  |
| **NS Health Card Number** |  |
| **NS HCN Expiry Date** |  |
| **Other Provincial Insurance #, if applicable** |  |
| **Other Prov. # Expiry Date** |  |
| **Complete Local Address** |  |
| **Complete Mailing/Out of Town Address** |  |
| **Home/Cell Phone #** |  |
| **Work Phone #** |  |
| **Emergency Contact (Next of Kin or Person to notify)** |  |
| **Emergency Contact Address** |  |
| **Emergency Contact Phone #** |  |
| **Relationship of Emergency Contact to Patient** |  |
| **Family Doctor** |  |
| **Attending Doctor** |  |
| **Workers’ Compensation** | **Yes/No Claim #:** |

**Please send to laboratory with specimen on behalf of New Patients or with change of above information. This form must be accompanied by specimen.**