MID
Canada Metabolic Inflammation Diagnostics Inc.

For more information: **1-647-4013185** ·
info@canadametabolicinflammationdiagnosicsinc.com

Patient Requisition

Report to Physician #:	Physician OHIP# (Ontario): Physician`s : Email: Other Provinces:	**CMID INC.** **Label**
Ordering Physician Name:	Name:	
Ordering Physician Address:	Address: Tel: Fax:	**Additional Info/ Label (if needed)**
Physician Signature:		
Copy to (Name):	Name:	
Bill to:	Patient to Pay (type of Pay): (Bill to Clinic):	
Patient Name (Last, First):		**Date of Birth:**_____/_____/_
Provincial Health Number:		**Sex:** ❑ **M** ❑ **F**
Patient address:		**Telephone #:**

Patient information (REQUIRED): Is the patient Diabetic? ❑ Yes ❑ No

Reason for testing (select all that apply):

- ❑ Family history
- ❑ Screening
- ❑ Consanguinity
- ❑ Supervision, normal high risk
- ❑ Supervision, diabetic
- ❑ High risk ethnicity
- ❑ Other_____

Ethnicity (select all that apply):

- ❑ Northern European *e.g. British, German*
- ❑ Southern European *e.g. Italian, Greek*
- ❑ French Canadian or Cajun
- ❑ Ashkenazi Jewish
- ❑ Other/Mixed Caucasian
- ❑ East Asian *e.g. Chinese, Japanese*
- ❑ South Asian *e.g. Indian, Pakistani*
- ❑ Southeast Asian *e.g. Filipino, Vietnamese*
- ❑ African or African American
- ❑ Hispanic
- ❑ Middle Eastern
- ❑ Native American
- ❑ Pacific Islander
- ❑ Unknown

TESTS REQUESTED

❑ **Cytokine Biochip Array (12 cytokines)**

❑ **Other Arrays/or tests**

Sample Type: ☐**Blood (EDTA: 4mL)** ☐**Ocular Aqueous fluid** ☐ **others**

Comments:

__/__/__
MM/DD/YYYY

_____/_____/_____ _____:_____ _____

Date Blood Collected (MM/DD/YYYY) **Time Blood Collected (HH:MM)** **Collector's Name**

**** PHOTOCOPY REQUISITION AND INCLUDE ORIGINAL WITH SAMPLE ****
(Testing performed at 4040 Finch Ave E. Suite #108, Scarborough, ON, M1S 4V5, Canada)

PATIENT CONSENT: I have read and signed the Patient Consent Form, which is available at Canada Metabolic Inflammation Diagnostics Inc. and remains with the ordering physician. I understand that 1 blood sample or any other body fluid will be taken by the healthcare practitioner, physician and/or a lab staff member. I acknowledge that my sample and personal health information will be sent to Canada Metabolic Inflammation Diagnostics Inc. for the purpose of testing at lab in Canada (address above). I also understand that Canada Metabolic Inflammation Diagnostics Inc. will contact me for a new blood sample if a test result cannot be provided from the original sample provided. I acknowledge that Canada Metabolic Inflammation Diagnostics Inc. will send the result to my ordering physician. I acknowledge that I am responsible for the full cost of testing.

Patient Sign Here: ..... **Date:** .....