Saskatchewan Health Authority

Roy Romanow Provincial Laboratory
FIT Requisition

Patient's Name & Address (Print Clearly)

Last Name _____

First Name _____

Phone #: (_____) _____- _____

Patient HSN

Birthdate
D / M / Y

Gender
☐ Male ☐ Female

Sending Location Phone #

Hospital ID, Ward or Room #

☐ In Patient

☐ Out Patient

Diagnosis

Medication

Collection Date
D / M / Y

Collection Time
H / M

Sample Type

☒ **Stool Specimen (FIT)**

Provider (Include First Name and Middle Initials)

Provider MSB#

Last Name:

First Name: Middle Initials:

Return Address (Provider/Clinic/Hospital) Clinic # _____

Provider or Lab Phone Number _____

If Additional Copy is Required:

☐ Fax to Ordering Provider - Fax # _____

☐ Provider _____ Fax # _____
Last Name First Name Initial

Address _____

City/Prov. _____ Postal Code _____

☒ **FIT (FOBT)**