



DT9240

**AUTHORIZATION FOR
MEDICAL BIOLOGY SERVICES
NOT AVAILABLE IN QUÉBEC**



TO BE COMPLETED BY THE HEALTH PROFESSIONAL AUTHORIZED TO PRESCRIBE											
Identification of insured person											
Surname at birth			Given name				Date of birth		Year	Month	Day
Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Newborn		Health insurance number				File number					
Address											
No.		Street			Apartment		City				
Province		Postal code		Area code	Telephone No.	Extension	Area code		Other telephone No.	Extension	
Identification of health professional authorized to prescribe											
Surname				Given name							
Speciality				Area code		Telephone No.	Extension	Area code		Fax No.	
Name of institution											
Address											
No.		Street			City			Province		Postal code	
Resource person to contact for information											
Surname			Given name				Area code		Telephone No.	Extension	
Diagnosis and services requested											
Diagnosis					OMIM code or other			Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical biology services requested											
Additional information on services requested											
In the case of a genetic analysis for a hereditary disease, confirmation of absence of a known family mutation <input type="checkbox"/>											
Clinical summary, justifying the requested services and, if relevant, the reason for requesting two or more concurrent tests for the same individual. If relevant, include additional documents (e.g. pedigree)											
Signature of health professional authorized to prescribe			Permit no			Date		Year	Month	Day	

Name of user	Health insurance number	File No.
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TO BE COMPLETED BY AUTHORIZING PHYSICIAN

**Identification of authorizing physician at a designated institution
(medical geneticist or laboratory physician whose competence in the field relevant to the requested analysis is officially recognized by the designated institution)**

Surname	Given name
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Specialty	Area code	Telephone No.	Extension	Area code	Fax No.
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Designated institution:

CHU Sainte-Justine
 CHUS
 CHUM
 CHU de Québec
 MUHC
 HMR
 HGJ

Address	No.	Street
	City	Province

The authorization is :

Authorized
 Canceled after discussion with the health professional authorized to prescribe

Institution where medical biology services will be provided

Name of hospital or laboratory	Surname and given name of physician in charge	Estimated cost of services (C\$)
		\$

Address	No.	Street	Office
	City	Province/State	Country

I certify that, to my knowledge, the medical biology services are:

clinically required;
 not available in Québec;
 not available in Canada (in the case of a request for services outside Canada).

Signature of the authorizing physician	Permit no	Date	Year	Month	Day
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Actual cost of services (C\$)	\$
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Signature of the director of financial resources of the medical biology cluster designated server institution.	Date	Year	Month	Day
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