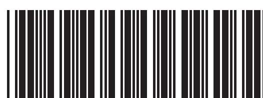
Santé
et Services sociaux
Québec



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: ☐ M ☐ F | ☐ 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 ☐ Yes ☐ 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 ☐

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.

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

Specialty	Area code	Telephone No.	Extension	Area code	Fax No.

Designated institution:

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

Address

No.	Street	
City	**Province**	**Postal code**

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**	**Postal code**

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

Actual cost of services (C$)	$

Signature of the director of financial resources of the medical biology cluster designated server institution.		Date	Year	Month	Day