www.iclabs.ca
Tel: 416-422-3000 ext. 300

Notes to Clinician:

1. *Explain test, cost and process to patient*
2. *Complete and fax this requisition to **ICL's secure fax # 416-385-1957***
3. *Your patient will be mailed a kit*

FIT Requisition

Clinician Information

Name: _____ Registration: _____

Address: _____
_____
_____
_____

Phone#: _____ Secure Fax# for Report: _____

Patient Information

Patient Last Name	Patient First Name
Date of Birth (dd/mm/yyyy)	Sex Male ☐ Female ☐

This test request does not meet criteria for OHIP billing ☐

Patient phone number(s) for ICL to collect payment from patient:

Cell _____ Home _____ Work_____

Patient full address for FIT kit mailing

_____
_____
_____
_____

-Each FIT Kit includes: FIT collection vial/paper, patient collection instructions, zip bag, return envelope
- A copy of the requisition and patient collection instructions is available at www.iclabs.ca