HEALTHCARE PROVIDER SETUP REQUEST FORM

Email completed form to **DL Data Entry Editors @** Copath.editors@*dyna***LIFE**.ca **or Fax to 780-701-1721.**

IMPORTANT: It is your responsibility to keep this information current. E-mail or fax changes as soon as possible.

DATE: _____

☐ NEW PHYSICIAN	☐ OFFICE RELOCATION (All patient files relocated with physician)	☐ PHYSICIAN PRACTICE/OFFICE CLOSURE

HEALTHCARE PROVIDER NAME: (Last) (First) (Middle) _____

Practitioner ID (9 digit #): _____ CARNA (5 digit #): _____

☐ Physician ☐ Pharmacist ☐ Optometrist ☐ Registered Nurse (RN) ☐ Nurse Practitioner (NP) ☐ Midwife (MW)

AFTER HOURS CONTACT INFORMATION – REQUIRED AS PER CPSA HEALTH PROFESSIONALS ACT STANDARDS OF PRACTICE

IMPORTANT: A MINIMUM OF ONE AFTER HOURS CONTACT NUMBER IS MANDATORY.

Phone Number 1: _____ ☐ **Cell** ☐ **Home** ☐ **Pager**

Phone Number 2: _____ ☐ **Cell** ☐ **Home** ☐ **Pager**

NEW LOCATION:- ONLY ONE FORM PER LOCATION IS REQUIRED FOR SET-UP (FOR ADDITIONAL HEALTHCARE PROVIDERS COMPLETE PAGE 2)

Building Name: _____ Clinic/Pharmacy Name: _____

Address: _____

City, Prov, Postal Code _____

Phone: _____ Secure Fax: _____ Email: _____

Hours & Days of Operation: _____

Effective Date: _____ Requester Name and Phone: _____

EXISTING LOCATION / RELOCATION **IS EXISTING LOCATION CLOSING?** ☐ Yes ☐ No

Building/Clinic Name: _____ Location Code: _____

Address: _____

City, Prov, Postal Code: _____

Phone: _____ Secure Fax: _____ Email: _____

SPECIMEN COLLECTION INFORMATION (FOR NEW LOCATIONS ONLY):

Supplies Required: ☐ Requisitions Only ☐ Specimen Collection Supplies

Do you typically collect specimens (swabs, paps, biopsies ?: ☐ No ☐ Yes (if yes please indicate days below)

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

DL EDITORS NOTIFICATION

Banner Sheet: _____ Method of Result Delivery: _____

Physician Code _____ Location Code: _____

Maintenance performed by: _____ NARP Sent _____

Maintenance Completed Date: _____ Notification date: _____

ADDITIONAL HEALTHCARE PROVIDER REQUEST FORM

List ALL Providers pertinent to this request. Each provider **must** provide a minimum of one after hours contact number.

LAST NAME	FIRST NAME	MIDDLE NAME	PRACTITIONER ID (9 DIGIT #)	AFTER HOURS CONTACT INFORMATION	PHYSICIAN CODE (DL USE ONLY)
				☐ Cell ☐ Home ☐ Pager	
				☐ Cell ☐ Home ☐ Pager	
				☐ Cell ☐ Home ☐ Pager	
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