



**CAN-AM
CRYO SERVICES
CORP**

1057 Main Street West, Suite 102
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Toll Free Fax 1-877-772-6387
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CAN-AM CRYOSERVICES INFECTIOUS DISEASE TESTING REQUISITION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Initials: _____

DOB: ____/____/____
 YYYY MM DD

OHIP:

Attention: Health Care Provider

Your patient has requested storage of reproductive tissues with our banking facility. In accordance with recommendations of the *CSA Standards for Tissues for Assisted Reproduction*, CAN-AM Cryoservices requests that your patient complete testing for the infectious diseases indicated below.

Please note: We require the exact tests listed below in order to maintain compliance and cannot accept substitutions. Blood must be drawn no more than 30 days prior to reproductive tissue storage, or no more than 15 days after storage.

Estimated Date of tissue storage: ____/____/____

Required Test		Test Code
<input checked="" type="checkbox"/> HIV 1&2 Antibody	HIV 1/2 EIA	-
<input checked="" type="checkbox"/> HTLV I&II Antibody	HTLV I/II EIA	-
<input checked="" type="checkbox"/> Hepatitis B Surface Antigen	HBsAg (diagnostic)	V13
<input checked="" type="checkbox"/> Hepatitis B Core Antibody	Anti-HBc (diagnostic)	V18
<input checked="" type="checkbox"/> Hepatitis C Virus Antibody	Anti-HCV	V19
<input checked="" type="checkbox"/> Syphilis	CMIA	S17
<input type="checkbox"/> Other: _____		_____
<input type="checkbox"/> 1 serum separator tube, spun for 10 min and frozen		

Please return to patient for shipment to CAN-AM by courier

Please send complete test results by fax or by mail to:

CAN-AM Cryoservices Corp.

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Please Note: Delays in receiving results may result in additional charges for the patient.

Thank you for assisting us in providing state-of-the-art fertility services to your patient.