CAN-AM CRYOSERVICES
DONOR EGG & STEM BANK

1605 Main Street West, Unit #3
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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. 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. Specimens for testing must be collected 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

☑ HIV 1&2 Antibody	☑ Hepatitis B Surface Antigen
☑ HIV NAT/PCR ***or*** HIV p24 Ag	☑ Hepatitis B Core Antibody
☑ HTLV I&II Antibody	☑ Hepatitis C Virus Antibody
☑ Chlamydia NAT/PCR (*urine*)	☑ Gonorrhea NAT/PCR (*urine*)
☑ Syphilis	☑ CMV IgG Ab or CMV Total Ab
☑ HCV NAT	☑ CMV IgM reflex to CMV Total
☑ WNV NAT (June 1 to Oct 31 bankings only)	☐ Other: _____

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

CAN-AM Cryoservices Corp.
1605 Main St. W., Unit #3, Hamilton, ON L8S 1E6
Fax 1-888-625-8653

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