Pharmacy Name: Phone Number:	<u>PATIENT INFORMATION</u>	
Address:  Phone Number:  Email:  Healthcard Number (if applicable):  Other Photo ID provided:  TEST INFORMATION  Name of Test Conducted:  Specimen Type:  Collection Date:  Time:  Test Type:  Sensitivity, Specificity:  Health Canada Authorization #:  Lot #/Expiration Date:  TESTING LOCATION  Pharmacy Name:  Phone Number:  Pharmacy Address:  Name of Pharmacy Practitioner:	Name:	Date of Birth:
Address:  Phone Number:  Email:  Healthcard Number (if applicable):  Other Photo ID provided:  TEST INFORMATION  Name of Test Conducted:  Specimen Type:  Collection Date:  Time:  Test Type:  Sensitivity, Specificity:  Health Canada Authorization #:  Lot #/Expiration Date:  TESTING LOCATION  Pharmacy Name:  Phone Number:  Pharmacy Address:  Name of Pharmacy Practitioner:		
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Healthcard Number (if applicable):  Other Photo ID provided:  TEST INFORMATION  Name of Test Conducted:  Specimen Type:  Collection Date:  Test Type:  Sensitivity, Specificity:  Health Canada Authorization #:  Lot #/Expiration Date:  TESTING LOCATION  Pharmacy Name:  Phone Number:  Pharmacy Address:  Name of Pharmacy Practitioner:	Address:	
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Other Photo ID provided:  TEST INFORMATION  Name of Test Conducted:  Specimen Type:  Collection Date:  Test Type:  Sensitivity, Specificity:  Health Canada Authorization #:  Lot #/Expiration Date:  TESTING LOCATION  Pharmacy Name:  Phone Number:		
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TEST INFORMATION  Name of Test Conducted:  Specimen Type:  Collection Date:  Test Type:  Sensitivity, Specificity:  Health Canada Authorization #:  Lot #/Expiration Date:  TESTING LOCATION  Pharmacy Name:  Phone Number:  Pharmacy Address:  Name of Pharmacy Practitioner:		
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Health Canada Authorization #:  Result:  FESTING LOCATION Pharmacy Name:  Pharmacy Address:  Name of Pharmacy Practitioner:		
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Pharmacy Name:  Phone Number:  Pharmacy Address:  Name of Pharmacy Practitioner:	Result:	
Pharmacy Name:  Phone Number:  Pharmacy Address:  Name of Pharmacy Practitioner:		
Pharmacy Address:  Name of Pharmacy Practitioner:	<u>FESTING LOCATION</u>	
Name of Pharmacy Practitioner:	Pharmacy Name:	Phone Number:
Name of Pharmacy Practitioner:		
	Pharmacy Address:	
Signature of Pharmacy Practitioner:  License #	Name of Pharmacy Practitioner:	
Signature of Pharmacy Practitioner: License #	Signature of Dhawaran Drastition or	licence #
	Signature of Pharmacy Practitioner:	License #