Children's Hospital
London Health Sciences Centre

Request for Sweat Test

Fax # 519-685-8130

Booking Clerk 519-685-8500 ext. 78944

Patient Name: _____

DOB:_____ HC#:_____

Address: _____

_____

Phone: _____

Referring Physician: _____

Referring Physician Fax Number: _____

Reason for Referral:_____

_____

_____

_____

Appointment Time and Date:_____

Location: LHSC PMDU B1-200

*****Please notify patient of appointment and provide attached Letter and Map*****