

# LABORATORY ORDER FORM

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

## Ordering Physician:

Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone: \_\_\_\_\_

## Laboratory Information:

Lab Name: \_\_\_\_\_

Lab Address: \_\_\_\_\_

Lab Phone: \_\_\_\_\_

## Specimen Information:

Specimen Type: \_\_\_\_\_

Collection Date/Time: \_\_\_\_\_

Collector Name: \_\_\_\_\_

## Tests Requested:

- Complete Blood Count (CBC)
- Comprehensive Metabolic Panel (CMP)
- Lipid Panel
- Thyroid Stimulating Hormone (TSH)
- Hemoglobin A1c
- Urinalysis
- Coagulation Panel
- Blood Culture
- Drug Screening
- Vitamin D
- Hepatitis Panel
- HIV Test
- COVID-19 PCR Test
- Other: \_\_\_\_\_

## Special Instructions / Comments:

## Billing Information:

Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

I hereby authorize the laboratory to perform the tests requested above. I certify that the information provided is accurate and complete to the best of my knowledge. I understand that test results will be released only to authorized individuals and used in compliance with applicable privacy laws and regulations. I consent to the use and disclosure of my protected health information as necessary for treatment, payment, and healthcare operations as permitted under United States law.

**PATIENT SIGNATURE**

**ORDERING PHYSICIAN SIGNATURE**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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