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

Signature: _____

ORDERING PHYSICIAN SIGNATURE

Signature: _____