PHOENIX CHILDREN'S Hospital®

LABORATORY SWEAT CHLORIDE TEST REQUEST

Apply Patient Label

Patient Information:			
Patient Name:		Date of Birth:	
Address:			Male ☐ Female ☐
		Home Phone:	( )
Insurance Company:		ID Number:	

Order Information:			
Diagnosis:		ICD 10 Code:	
Ordering Physician:		Physician Phone:	
Physician Address:		Physician Fax:	

Practitioner Signature:		Date:	
Printed Name:		Time:	

PLEASE NOTE THE FOLLOWING TEST CONTRAINDICATIONS:

- Patients with an implanted device, such as a defibrillator, neurostimulator, pacemaker, or ECG monitor.
- Patients with a history of epilepsy or seizures.
- Patients who are pregnant.
- Patients that have a known sensitivity or allergy to any ingredient used for this testing.
- Over damaged, denuded skin or recent scar tissue.
- Patients with cardiac conditions or with suspected heart problems

*For questions regarding these contraindications, please contact Phoenix Children's Hospital Sweat Lab at (602) 933-0314

THESE TESTS MUST BE SCHEDULED IN ADVANCE WITH THE PCH SWEAT LAB 602-933-0314

NOTE: Diagnosis/ICD-10 Codes, Insurance Authorization and Practitioner's Signature are required before testing can be performed.

THIS FORM MUST BE FAXED TO: (602) 933-0327