Memorial
LAB SERVICES

Authorization for Restricted or Off-Formulary Lab Tests

Information with * is required to be completed by Requesting Physician**

Test Name: _____

Specimen Type: _____

Methodology: _____

Recommended Test Lab: _____ Client Price: _____

Requesting Physician (Please Print): _____

*****Please provide patient diagnosis and a detailed explanation as to how results of requested test(s) will influence your clinical management and care of this patient. If the patient is a hospital in-patient, please explain how these results will influence your treatment plan during current admission. Also include indication for use (including a copy of the patient chart is acceptable).**

If the above testing request is not approved by the Referred Testing Committee, testing will be **cancelled**. Your office will be notified with the approval/denial .

Patient Information

Patient Name:_____ Date of Birth:_____

Insurance Provider: _____

***Signature of Requesting Physician**: _____Date: _____

For Internal Use Only

Performing Lab:_____ Approved: Yes or No Date:_____

Return completed form and any necessary literature to Memorial Lab Services:

Attention: Referred Testing Department Phone #: 217-788-3816

Fax to #: 217-757-7482