

Miscellaneous Test Request Form

Instructions: Please complete all sections. If any information is left blank the form will not be reviewed. Send-out requests will be processed M-F 7am-6pm. Print form and deliver to Lab Receiving Area.

Patient Name: _____ DOB: _____

MRN: _____ Sex: M F

Patient Address (City, State, Zip): _____

Insurance Information (Carrier, ID#, Address): _____

Inpatient Outpatient ICD-10 Code (outpatient only): _____

Requested Test: _____

Medical Necessity (Justification): _____

Does this test require patient consent: Y N

Requestor details

Name: _____ Title: _____

Office Address: _____

Contact Phone: _____ CWID (NYP affiliates): _____

Requestor's Signature: _____

Laboratory Use Only

Test Location: _____ Test Code: _____

Specimen Details

Container Type: _____ Storage Temp: _____ Specimen Type: _____

Medical Director Approval: Y N

Medical Director Signature: _____ Date: _____

Was Requestor Notified? Y N

Name of Person Notified: _____

Date: _____

Staff Signature: _____