NewYork-Presbyterian Brooklyn Methodist Hospital
Department of Pathology and Laboratory Medicine

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: _____

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