ST. JOSEPH'S/CANDLER OUTREACH LABORATORY
TEST ADD-ON REQUESTS

Fax to **912-819-6906**

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security No.: _____

Specimen collected (Date/Time): _____

Test(s) to be added: _____

_____

Diagnosis for added test(s): _____

Requesting Provider: _____

Person completing request: _____

Office telephone: _____

_____
Provider's signature/Date

For internal use only:

Request received at (date/time) _____

Request received by _____

Ordered in computer? _____ Specimen #: _____