Request to Add on Tests

St. John's Medical Center Clinical Lab

Please fax completed form to 739-7323

You will be notified if for any reason the test(s) cannot be added.

Patient Name:

Date of Birth:

Original date of testing:

Test(s) to be added:

Diagnosis:

Ordering Physician Name:

Signature:

Date:

Internal use only.

Completed by: Date: Time: