SSMHealth
Laboratory Services

SSM Recovery at Home

Lab Specimen Drop off Form

Patient name:_____

DOB: _____

Ordering Physician:

_____

Test(s) Ordered:

_____

Fasting: Y / N / NA From Indwelling Catheter: Y / N

If drug level, last dose: Date: _____ Time: _____

If culture, indicate source: _____

If urine, indicate source:_____

Collected by: _____

Epic ID: _____

Collector Phone Number: _____

Collection Date:_____ Time:_____

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