



SSM Recovery at Home

Lab Specimen Drop off Form

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Patient name:	Patient name:
DOB:	DOB:/
Ordering Physician:	Ordering Physician:
Test(s) Ordered:	Test(s) Ordered:
Fasting: Y / N / NA From Indwelling Catheter: Y / N	Fasting: Y / N / NA From Indwelling Catheter: Y / N
If drug level, last dose: Date: Time:	If drug level, last dose: Date: Time:
If culture, indicate source:	If culture, indicate source:
If urine, indicate source:	If urine, indicate source:
Collected by:	Collected by:
Epic ID:	Epic ID:
Collector Phone Number:	Collector Phone Number:
Collection Date: Time:	Collection Date: Time: