Laboratory Requisition

119 East Ogden Suite 15LL ▪ Hinsdale, IL 60521 Tel# (630) 920-1909 Fax# (630) 920-1699

Account:

Request date: _____ STAT: Yes / No
Collection date: _____Draw Date:_____
Phlebotomist: _____Draw Time:_____
Ordering MD/RN_____

Patient Name:	**SS#**
DOB:	**Sex: Male Female**
Address:	**City, State, Zip:**
Phone:	**Ordering Physician:**
Insurance:	**Physician's NPI:**
Insurance ID:	**Physician's Phone:**

Diagnoses /ICD-10

1.	2.	3.	4.	5.	6.	7.	8.

Test Ordered:

	CMP Comprehensive Metabolic Panel		**T-3 Total**		**HgBA1c**
	BMP Basic Metabolic Panel		**T-4 Total**		**URINALYSIS**
	PT/INR		**T-4 Free**		**URINALYSIS with C&S**
	CBC Complete Blood Count		**TSH**		**Digoxin**
	LIPID PANEL		**Vitamin B12**		**Vitamin D, 25-Hydroxy**

Other Tests:

I authorize the release to my insurance carrier of any medical information necessary to process this claim and I authorize payment of medical benefits directly to Quality Lab One. ABN on file in patient record.

Patient's Signature:_____

Note: Only test that are medically necessary for those diagnosis or treatment of the patient may be submitted for Medicare/Medicaid reimbursement. Documentation supporting medical necessity must be present in the Patient's medical record.

Indicate drop off location

DROP OFF	**LOCATION:**	**NURSE DRAWING TEST:**	**_____Fasting _____Random**

Requestor: Healthcare Provider's Name and signature

Name:	**Signature:**

ALL RESULTS SUBJECT TO MINIMUM 12-24 HOUR RESPONSE FROM TIME OF SPECIMEN DELIVERY.