

Add-on Test Requisition

Today's Date _____ PA# _____

Patient _____ DOB _____

Diagnosis Code(s) _____

Office Fax _____

Physician Signature _____

TEST TO BE ADDED

_____	_____
_____	_____
_____	_____
_____	_____

Fax this request for additional testing to the Lab. PLEASE DO NOT CALL ORDERS IN. Upon completion, this requisition will be faxed back to notify you that we received it and to let you know what if any action we are taking.

For Lab Use Only

___ Done	___ Quantity Not Sufficient
___ Specimen too old	___ Wrong specimen drawn
___ _____	

Lab Personnel: _____ Date: _____

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