Seattle Children's Hospital Laboratory
REQUEST FOR ADDITIONAL TESTING

Patient Name: (Last Name, First Name)

_____

DOB:____/____/_____SEX: M / F

SCH MRN: _____

FORM FILLED OUT BY:

_____

PATIENT MRN (SENDING INSTITUTION):

_____

NAME OF BILLABLE PROVIDER REQUESTING TEST(S):_____

PROVIDER'S PHONE/PAGER: _____ FAX: _____

REQUESTING INSTITUTION: _____

DATE SPECIMEN(S) COLLECTED: _____

TEST(S) REQUESTED:

_____

_____

_____

_____

_____

_____

(If this form was filled out for the provider, please fax it to the provider and use this as your order form. Form was faxed to provider Date/Time :_____)

(***Attention Provider*: Fill in the diagnosis code. Sign the order. Fax it to your lab.**

**If your institution does not have a Lab, please fax it to Seattle Children's Lab at the number below)*

****SIGNATURE AND DIAGNOSIS REQUIRED FOR ALL ORDERS****

DIAGNOSIS CODE(S):_____

PROVIDER'S SIGNATURE: _____

THEN FAX THIS SIGNED FORM TO YOUR LABORATORY ASAP **If your institution does not have a Lab, please fax this form to Seattle Children's Lab at* ***(206) 987-2631***.

(For Original Sending Institution Laboratory Use Only.)

Request Received (Date):_____

Authorized By (Please Print):_____

PRICE: _____

CPT CODES: _____

FAX AUTHORIZED FORM TO SEATTLE CHILDREN'S HOSPITAL LAB AT FAX: ***(206) 987-2631***

For questions please call Lab Client Services at (206) 987-2617.

MS 4/29/2015