ADD ON REQUISITION

Fax to: 607-547-6717

DATE/TIME of REQUEST: ______________________

PATIENT: ___________________________ ICD-9 CODE: __________________

MEDICAL RECORD NUMBER: _______________ BILLING #: _______________

PHYSICIAN REQUESTING: ____________________________

PERSON MAKING REQUEST (if not ordering provider): ____________________________

TEST(s) TO BE ADDED: ____________________________________________

ADD TO ACQN #: _______________ COLLECTION DATE/TIME: _______________

NEW ACQN #: _______________ RECEIVED DATE/TIME: _______________

CALL RECEIVED BY, INITIALS ____________ [☐] Read Back Order

NAME AND NUMBER OR PAGE TO CONTACT IF UNABLE TO ADD ON: ____________________________

COMPLETED BY: ____________________________
LST’S INITIALS: ____________

FOR LAB USE ONLY (Chemistry add ons)
Shelf _________ Rack # _________ Row # _________ Column _________

________________________________________________________________________

IF UNABLE TO FOLLOW THROUGH

REASON (QNS, HEMOLYZED, ETC): ____________________________

NEW SPECIMEN REQUESTED:
PERSON CONTACTED: ____________________________ DATE/TIME: _______________
INITIALS: ____________________________

COMMENTS: ____________________________________________________________

MUST be filed DAILY in CLP with Requisitions