Affix Patient Label

Name________________________________ Date of Birth__________

LABORATORY ADD-ON TEST REQUEST
(SPECIMEN PREVIOUSLY COLLECTED)

BRONSON METHODIST HOSPITAL LABORATORY

601 John Street, Box 37
Kalamazoo, Michigan 49007
Phone: (269) 341-6440

Lab Fax: (269) 341-8423
Cytology/Pathology Fax: (269) 341-6861

Please fill in the form below and fax to the number above. Bronson Laboratory staff will check to see if adequate sample is available to perform the requested testing. If sample is available, testing will be performed, and this form will serve as the test order as required by CLIA (Clinical Laboratory Improvement Act) regulations. If no sample is available, Bronson Laboratory staff will contact you at the number you have provided below. Thank You.

Copies of blank form are located on the Bronson Intranet or contact laboratory for additional copies.

Patient & Sample Information:

Patient Name:	Medical Record # or Date of Birth:
Specimen Collection Date:	
Test(s) to Add:	Diagnostic Information (ICD-9) for added tests:
Additional Comments:	

Provider Office Information:

Provider Signature:	Provider Phone #:
Print Provider Name:	Date & Time Order Placed:
Provider Office Contact Person:	

This section for Bronson Laboratory Staff Use Only:

Specimen Available & Adequate for Testing? Yes No
If Yes, test codes ordered, labels generated and specimen submitted for testing? Yes No
If No, physician office contacted: Date: Time: Person Contacted:
Was form given to Registration for update of additional diagnostic info: Yes No
Laboratory employee Tech Code:_____________
File ***COMPLETED*** Form in the “To be scanned” tray in the phone room or accession