Phone: 480-990-1335 Fax Orders to: 480-990-1337 www.ccllabs.com

DATE:_____ **CLIENT OFFICE NAME**:_____

ORDERING PHYSICIAN: _____ **NPI #**: _____

PHONE#: _____FAX#_____

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

PATIENT/CONTACT PHONE #: _____

DOB: _____ **SEX:** _____

INSURANCE INFORMATION

MEDICARE: _____

OTHER: _____

TESTS TO BE PERFORMED

[] CBC W. DIFF	[] LIPID PANEL	[] CMP	[] BMP	[] HEPATIC FNL
[] ESR	[] CRP	[] VIT-D25	[] PSA	[] PT/INR PNL
[] CEA	[] TSH	[] IRON PNL	[] RENAL PNL	[] URIC ACID
[] VIT B12/FOLATE	[] FERRITIN	[] CPK	[] DILANTIN	[] DIGOXIN
[] TESTOSTERONE PNL	[] THYROID PNL	[] T3 FREE	[] T4 FREE	[] VALPROIC ACID
[] HgbA1C	[] MAGNESIUM	[] PHOSPHORUS	[] URINALYSIS	[] MICROALBUMIN

CULTURES: [] URINE [] BLOOD [] WOUND

OTHER TESTS:_____

DIAGNOSIS/ICD-10 CODES: _____

[ ] DATE TO BE COLLECTED: _____ **FASTING: [ ] YES [ ] NO**

[ ] STANDING ORDER; Frequency: _____ *COMPLETED BY:_____

Send Additional Fax Copy to: _____

* The undersigned represents that this patient qualifies as homebound under CMS rules and regulations.