CENTRAL CLINICAL LABS

Phone: 844-990-1335 Fax Orders to: 855-631-0414 www.ccllabs.com

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

PHONE#: _____ **FAX#:** _____

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

PROVIDER SIGNATURE: _____

PROVIDER SIGNATURE REQUIRED UNLESS A SIGNED ORDER IS ATTACHED

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-HS	☐ 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 ☐ STOOL ☐ 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