



Phone: 844-990-1335 ▪ Fax Orders to: 855-631-0414 ▪ 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

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

CULTURES: URINE BLOOD WOUND

OTHER TEST: _____

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