Trace Lab Collections OFFICE USE ONLY

Collection Date: ____/_____/_____
Collection Time: ____:_____AM/PM
Phlebotomist: _____

Ph:984-345-5930
fax:984-345-5787

MOBILE LAB REQUEST FORM

Inaccurate or Incomplete information may delay results and/or collection

Patient Information:

SSN# _____-_____-_____

Patient Name: _____ D.O.B: ____/____/_____ Gender: M/F
FIRST NAME MIDDLE NAME LAST NAME

Insured Responsible Party: _____ Phone Number: (____) _____
(if different from patient) FIRST NAME MIDDLE NAME LAST NAME

Collection Address: _____
City State Zip code

Insurance Carrier: _____ Policy #: _____ Group #: _____

Physician Information:

Name of Physician: _____ NPI or UPIN #: _____

Office Location: _____
City State Zip code

Physician Phone Number: (____) _____ Fax Results: (____) _____

Test Information:

ICD - 9 Codes (enter all that apply)								

Test Name(s): _____
_____

Special Instructions: _____
_____

Please Circle: Fasting: YES / NO Standing Order: YES / NO Patient Home Bound: YES / NO

If Standing Order please enter start and end date: Monthly _____ Weekly_____

Start Date: _____/_____/_____ End Date: _____/_____/_____

Doctor Signature: _____ Initials: _____ Date: ____/_____/_____

Collection Site: HOME NURSING HOME ASSISTED LIVING FACILITY (Name of Facility):

PLEASE SEND FORM TO "Trace Lab Collections" BY FAX OR EMAIL.
FAX: (984)345-5787 / E-mail: info@tracelabcollections.com (Subject Line: Order Mobile Collection)