Laboratory Patient Demographic Form
Marshall County Health Department

(Please Print)

Name:_____

Date of Birth:_____

Address:_____

City:_____

State:_____

Zip Code:_____

Phone Number:_____

Primary Care Physician_____

I hereby authorize Marshall County Health Department to provide blood draw following my doctor order or MCHD standing order. I agree to assume responsibility for payment for this service. All results will be sent to ordering provider.

X_____ X_____ X_____

(Signature) **(Date)** **(Time)**

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For Health Department use only

What Lab Provider was used:

_____ **Quest** _____**Lab Corp** _____**CDD** _____**KDHE**

Notes:_____

_____

_____

Nurse Signature_____ **Date**_____