

NEW LABORATORY TEST REQUEST FORM

Seattle Children's Hospital Laboratory requires the test order requested to go through a director approval process. This test(s) is flagged because it is not on the approved reference lab test list. The following information must be provided to the Laboratory Director for review and approval. You may be asked to present this information to Seattle Children's Hospital Laboratory Test Stewardship Committee for further discussion.

You will typically receive a response the following business day.

If the specimen has already been collected please return form within 24 hours.

Test Name	
Preferred Reference Lab (if applicable)	
Test Code (if applicable)	
Test Description	
Test Methodology	
Preferred Specimen & Sample Stability	
If this test is replacing an existing standard approach to care, please explain.	

If this request is regarding a specific patient, please complete these patient demographics.			
Patient Name			
Date of Birth		MRN	
Gender			

Requesting Provider Name	
Primary Contact #	
Email Address	
Provider Specialty	

MEDICAL NECESSITY AND REFERENCES

Please provide a detailed explanation of medical necessity/how results of requested test(s) will influence patient clinical management and care. If the patient is a hospital in-patient, please explain how these results will influence the treatment plan during current admission. Provide references. **This portion is critical for proper medical director evaluation of the requested laboratory testing.**



Medical Necessity:

References:

Outcome:

Include date of Committee review, discussion, and final decision or plan for escalation.