Seattle Children's Hospital Laboratory

REQUEST FOR ADDITIONAL TESTING

TIME STAMP DATE

Patient Name: _____

Date of Birth: _____

External MRN: _____

ORDER TAKEN & READ BACK BY:

_____

ORDER PROVIDED BY:

_____

PHYSICIAN AUTHORIZING TESTING: _____

PHYSICIAN'S CLINIC / FACILITY: _____

PHYSICIAN'S PHONE / PAGER#: _____ FAX#: _____

DATE FAXED TO PROVIDER FOR SIGNATURE: _____

TEST(S) REQUESTED:

_____

_____

_____

_____

(Lab Staff –Testing may proceed prior to provider signature. After order entry, file this order with the daily requisitions. Lab Client Services is responsible for ensuring that a signed order is returned to the lab by the requesting provider.)

(Provider Instructions: Please fill in the diagnosis code(s), sign the order, & fax it back. FYI – Additional testing will be billed in the same manner as initial testing.)

****SIGNATURE AND ICD-10 CODE(S) ARE REQUIRED ON ALL ORDERS****

ICD-10 DIAGNOSIS CODE(S): _____

PROVIDER SIGNATURE: _____

(FAX THE SIGNED FORM TO: SCH Lab Add-On Fax @ (206) 987-2631 ASAP)