Quest Diagnostics®

NATIONAL ACCOUNTS

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M / D D / YEAR | SEX

PATIENT SOCIAL SECURITY # - - | OFFICE / PATIENT ID #

ROOM # | LAB REFERENCE # | PATIENT PHONE # ( )

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

CITY | STATE | ZIP

DID YOU REMEMBER...

TO REQUEST OR MARK TEST(S)?

TO PROVIDE ORDER CODE(S) FOR HANDWRITTEN TESTS?

ACCOUNT #: MEDTRONIC SOFANOR DANEK
NAME: 1201 S COLLEGEVILLE RD
ADDRESS: COLLEGEVILLE, PA 19426-2998
CITY, STATE, ZIP
TELEPHONE #19426

DATE COLLECTED | TIME : ☐ AM ☐ PM | TOTAL VOL/HRS. ____ ML ____ HR | ☐ Fasting ☐ Non Fasting

U.P.I.N. ORDERING PHYSICIAN AND/OR PAYORS

U.P.I.N. ____
STATE LICENSE ____

☐ ADDITIONAL PHYS.: Dr. ____

☐ Fax
Results to: ( )

Send Duplicate Report to:
Client # OR NAME: ____
ADDRESS: ____
CITY: ____ STATE ____ ZIP ____

CLIENT BILL ONLY

SAMPLE

( )@ 501 HEP B CORE AB, TOTAL
( )@ 4848 HEP B CORE IGM AB
( )@ 498 HEP B SURF AG W/CONF
( )@ 8475 HEP B SURFACE AB QN
( )@ 499 HEP B SURFACE AB QL
( )@ 8472 HEPATITIS C VIRUS AB
( ) 10260 HIV 1 HIV 2 AB W/RFX--FOR ALL STATES EXCEPT NEW YORK-NEW YORK MUST USE NY SPECIFIC REQ
( )@ 799 RPR (MONITOR) W/REFL

( ) 3259 DRAW FEE, PSC SPEC.

NOTE TO PHYSICIANS: PLEASE ENSURE THAT YOUR NAME, ADDRESS AND UPIN/LICENCE NUMBER HAS BEEN COMPLETED IN THE 'SEND DUPLICATE REPORT TO' FIELD AND THAT YOUR FAX NUMBER HAS BEEN PROVIDED IN THE 'FAX RESULTS TO' FIELD. THIS INFORMATION IS REQUIRED EVEN IF YOU ARE A CURRENT CLIENT OF QUEST DIAGNOSTICS.

NO ADDITIONAL TESTS ARE PERMITTED TO BE ORDERED ON THIS TEST REQUISITION

ADDITIONAL TESTS: (MUST INCLUDE COMPLETE TEST NAME AND ORDER CODE.)

*** Additional charge for ID/Susceptibility studies.**
Reflex tests are performed at an additional charge.

COMMENTS, CLINICAL INFORMATION:

TOTAL TESTS ORDERED

Physician Signature

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