



Request For Add-On Testing

The United States Code of Federal Regulations *Requires a Written and Signed Request* be Forwarded to Our Laboratory when Additional Testing is Required.

<u>For Physician Use</u> <u>Must be Completed or request cannot be fulfilled</u>	
Date _____	Your Fax Number for Confirmation _____
Practice or Physician's Name (please print) _____	
Patient Name _____	
Date of Birth _____	Collection Date _____
<u>Add-On Test Names & Diagnoses</u>	
Test Name _____	Diagnosis (ICD-9) _____
Test Name _____	Diagnosis (ICD-9) _____
Test Name _____	Diagnosis (ICD-9) _____
_____ *Signature of Physician (or authorized designee)	

Fax completed form to: 301-665-4949

<u>For Lab Use Only</u>	
Test will be Performed _____	QNS _____ Sample too Old _____
Other _____	

Depending upon the type of specimen, tests may be added-on for up to 4 days.

**FORM MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST
CANNOT BE FULFILLED**