



SWEDISH

Swedish Laboratory Services

21601 76th Avenue West

Edmonds, WA 98026

T 425.640.4179

F 425.640.4426

ADD-ON TEST REQUEST

Please print clearly

Patient Name (Last) _____ (first) _____ (Mi) _____

Date of Birth (Month) _____ (Day) _____ (Year) _____

Ordering Practitioner (Last) _____ (First) _____

Ordering Location _____

Original Tests Ordered _____

Test(s) to be added:

Test _____ DX Code _____

Test _____ DX Code _____

Test _____ DX Code _____

Test _____ DX Code _____

Test _____ DX Code _____

Special Instructions _____

Order Submitted By _____

Phone Number _____ Fax Number _____

Authorization Signature _____ **Date** _____

Federal Regulation #493.1105 requires written authorization for all laboratory test orders. These must be submitted within 30 days of any verbal request to the referring laboratory.

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify Swedish/Edmonds Laboratory at (425) 640-4179 immediately and arrange for the return or destruction of these documents.

FAX ORDER TO 425-640-4426

Place Label Here

For Lab Use Only

Accession#

Date of collection _____

Time of original collection _____