

LAB TEST REQUEST FORM 9618

5/98;3/03;4/03;10/03;1/04;7/04;4/05;7/05;10/05;4/06;10/4/06;8/1/07,
1/14/08;7/6/09;1/4/10;7/19/12;11/29/12, 7/1/13, 3/18/15, 5/15/15;8/27/15,
4/25/16;2/10/22,2/16/26

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Bassett Healthcare Network (LAB320) PT/INR Coag Confirmation DOWNTIME Referral Log
Room Temperature

Specimen Date: _____ Specimen Time: _____ Ordering Provider: _____ Collected By: _____ Finger Stick Result: _____	Patient Information	Specimen #
	Pt. Name _____ Loc.: _____ Pt. MRN _____ D.O.S. _____ Visit Number _____ OR Place Patient Registration label here and on second ply.	
Specimen Date: _____ Specimen Time: _____ Ordering Provider: _____ Collected By: _____ Finger Stick Result: _____	Patient Information	Specimen #
	Pt. Name _____ Loc.: _____ Pt. MRN _____ D.O.S. _____ Visit Number _____ OR Place Patient Registration label here and on second ply.	
Specimen Date: _____ Specimen Time: _____ Ordering Provider: _____ Collected By: _____ Finger Stick Result: _____	Patient Information	Specimen #
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	Pt. Name _____ Loc.: _____ Pt. MRN _____ D.O.S. _____ Visit Number _____ OR Place Patient Registration label here and on second ply.	

PLEASE BE SURE THAT EVERY PATIENT LISTED ON THE ACCESSION LOG HAS THE APPROPRIATE SPECIMEN PLACED IN THE BAG

Comments:

PLEASE PRINT

Courier Name	Pick up Time	Originating Site Contact Name	Time Received at Lab	Receiver Name