PLEASE COMPLETE THIS FORM AND FAX TO

862-257-1419 (FAX)

OXFORD CLINICAL LABORATORY

HOME DRAW REQUISITION

PLEASE FILL OUT CLEARLY, USING CAPITAL LETTERS

OFFICE USE ONLY

MILES: _____

Date: ___/___/___ Requested Date of Service: ___/___/___ Fasting: Y/N Special Instructions: ___/___/___

PATIENT

Last Name: _____ First Name: _____

Address Line 1: _____

Address Line 2: _____ State: _____ ZIP: _____

Phone: _____-_____-_____ Sex: _____ DOB: ___/___/___ SSN#: _____

Insurance: _____ ID#: _____ Group#: _____

PROVIDER

Facility Name: _____ Phone: _____-_____-_____

Address: _____ Fax: _____-_____-_____

Ordering Doctor: _____

UPIN#: _____ MD#: _____ NPI#: _____

PANELS & PROFILES

- ☐ Comp. Metabolic Panel
- ☐ Basic Metabolic Panel
- ☐ Lipid Profile
- ☐ Hepatic Panel
- ☐ Electrolytes
- ☐ Thyroid Panel TSH, T4, T3, T3U
- ☐ Anemia Profile

INDIVIUAL TESTS

- ☐ ANA
- ☐ BNP
- ☐ CBC
- ☐ CEA
- ☐ CULTURE THROAT
- ☐ CULTURE URINE
- ☐ DIGOXIN
- ☐ FERRITIN
- ☐ FECAL OCCULT BLOOD
- ☐ FRUCTOSAMINE
- ☐ GLUCOSE
- ☐ Hgb A1C
- ☐ IRON
- ☐ PSA
- ☐ PT/NR
- ☐ TSH
- ☐ URINALYSIS

DIAGNOSIS

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

ADDITONAL TESTS

1) _____ 5) _____ 9) _____
2) _____ 6) _____ 10) _____
3) _____ 7) _____ 11) _____
4) _____ 8) _____ 12) _____

FREQUENCY

START: ___/___/___ END: ___/___/___

EVERY: _____ WEEKS

EVERY: _____ MONTHS

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