

URMC LABS TEST ADD-ON REQUEST FORM
***Indicates Required Field**

*TODAY'S DATE: _____

*PATIENT NAME: _____

*DOB: _____ **OR** MRN: _____

*DIAGNOSIS: _____

DATE OF BLOOD DRAW (SPECIMEN COLLECTION): _____

*TEST(S) TO BE ADDED:

*REQUESTING PROVIDER: _____

*PROVIDER SIGNATURE (REQUIRED BY NYS): _____

PROVIDER PHONE: _____ FAX: _____

PLEASE FAX TO: (585) 424-5527
OR
IF STAT, PLEASE CALL: (585) 350-2600, OPTION 3

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR CLIENT SERVICES DEPARTMENT
AT (585) 350-2600, OPTION 3**

