



URMC LABS

RESTRICTED SEND-OUT TEST REQUEST PHYSICIAN CERTIFICATION OF MEDICAL NEED

Directions: Please fill out this form for all **RESTRICTED** send-outs test and submit to the lab with the test requisition or provide to the patient prior to blood draw.

For Information and Results Call
Pathology and Lab Medicine
Client Services **(585) 350-2600**
option 3

Spark Card / Patient Sticker or Print Patient Information

Name (Last, First, MI)

Physician: _____

Date of Birth

Sex: (circle) M F

Patient

Patient Medical Record #:

Account #:

Location: _____

Phone: _____

Chief Complaint

1. _____
2. _____
3. _____

Collection Date & Time:

Test Requested:

Other Relevant Information:

Specimen Type Submitted

- Blood __BL__GRN__LAV__RT__SST
- Urine (specify source)
- Stool
- Fluid (specify type)

- Tissue
- Other: _____

I _____, M.D. am the Physician of record or a Consulting Physician caring for the patient identified above. I am requesting a laboratory assay that is not provided by the Clinical Laboratories of Strong Memorial Hospital/Highland Hospital and will require shipment of sample to an outside reference laboratory to perform this assay. I understand that the time required to process, ship, and to receive results from an outside reference laboratory generally requires a minimum of five (5) business days, and that for certain assays, results may not be available for several weeks.

In making this request I certify that the results of the laboratory assay(s) that I have requested above are medically necessitated and are likely to alter my diagnosis and/or my treatment plan for this patient.

Signed _____, M.D.
(Physician)
Print Name _____, M.D.
Pager # (required) _____