Laboratory Test Add-On Request

Children's Hospitals and Clinics of Minnesota

Date: __________________**Requesting Location:**_____________________________

Patient Name:____

Date of Birth:____

Medical Record Number:____

Original Sample Collection Date:____

Diagnosis: ____

Name of Person Adding Test(s):____

Contact Phone Number: ____

*****Please list requested tests in order of priority*****

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

<u>Please fax completed test add-on request form to one of the following:</u>
Minneapolis Laboratory: 612-813-6951 (56951)
Saint Paul Laboratory: 651-220-5280 (65280)

If a test add-on request **CANNOT** be completed, you will be notified by Children's Laboratory staff within 24 hours

FOR LAB USE ONLY		
[ ] Testing added	[ ] Sample too old	[ ] Sample QNS
[ ] Sample inappropriate	[ ] Sample not located	[ ] Other
Comments:	Tech code:	

*****For any questions, please contact one of the following*****
Minneapolis Laboratory 612-813-6280 (56280)
Saint Paul Laboratory 651-220-6550 (66550)