CLINICAL STICKS,LLC USE ONLY Collection Date: ____/_____/______ Collection Time: ____:_____AM/PM
Phlebotomist: ___________________________

1Galleria Blvd Ste. # 1900
Metairie , La 70001
PH: (504) 656-4071/ FAX: (800) 541-8319

**PLEASE SEND THIS FORM TO "CLINICAL STICKS" BY FAX OR EMAIL:**

**FAX: (800) 541-8319 / E-mail: orders.clinicalsticks@gmail.com (Subject Line: Mobile Collection**

# MOBILE LAB REQUEST FORM

*Inaccurate or Incomplete information may delay results and/or collection*

**Patient Information:**

**Patient Name:** ____________________________________________________________

**D.O.B:**____/____/________ **Gender: M/F**

**INSURANCE :**

**Insured Responsible Party:** _____________________________________________________ **Phone Number: (____)** ______________________

**(if different from patient)**

**Collection Address:**

_____________________________________________________________________________________________

**City State Zip code**

**Insurance Carrier:** _________________________________ **Policy #:** _________________________ **Group #:** ____________________________

**Physician Information:**

**Name of Physician:** ___________________________________________ **NPI or UPIN #:** ____________________________________

**Office Location:**

____________________________________________________________________________________________

**City State Zip code**

**Physician Phone Number: (____) ______________________________ Fax Results: (____) __________________________**

**Test Information:**

**ICD - 9 Codes**
**(enter all that apply)**
**Test Name(s):**
__________________________________________________________________________________
__________________________________________________________________________________________

**Special Instructions:**
______________________________________________________________________________
__________________________________________________________________________________________

**Please Circle: Fasting: YES / NO Standing Order: YES / NO Patient Home Bound: YES / NO**

**If Standing Order please enter start and end date: Monthly _____ Weekly_____**

**Start Date: ________/_________/_________ End Date: ________/_________/_________**

**Doctor Signature: ___________________________________________ Initials: __________ Date: ____/______/________**

**Collection Site: ___HOME ____NURSING HOME ___ASSISTED LIVING FACILITY (Name of Facility): ___________________________**

**Resulting lab:___QUEST DIAGNOSTICS _____LAB CORP _____CPL _____OTHER**

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