RAPIDCHECK MOBILE LABS OFFICE USE ONLY

Collection Date: ____/_____/_____

Collection Time: ____:_____AM/PM

Phlebotomist: _____

RapidCheck MOBILE LABS

2309 W Cone Blvd Ste # 220-C
Greensboro NC, 27408
PH:(855)937-2278 Fax:(336)664-8173

MOBILE LAB REQUEST FORM

Inaccurate or Incomplete information may delay results and/or collection

Patient Information:

SSN# _____-_____-_____

Patient Name: _____ D.O.B: ____/____/_____ Gender: M/F
FIRST NAME MIDDLE NAME LAST NAME

Insured Responsible Party: _____ Phone Number: (____) _____
(if different from patient) FIRST NAME MIDDLE NAME LAST NAME

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):

PLEASE SEND FORM TO "RAPIDCHECK MOBILE LABS" BY FAX OR EMAIL.
FAX: (336) 664-8173 / E-mail: orders@rapidcheckmobilelabs (Subject Line: Mobile Collection)