



OHSU Health

LABORATORY TESTING REQUISITION

PATIENT INFORMATION																																																																																									
PATIENT LAST NAME			FIRST			MI	SEX	BIRTH DATE																																																																																	
LABORATORY ACCESSION NO./ PATIENT IDENTIFICATION NO.					DATE COLLECTED		TIME COLLECTED																																																																																		
RESPONSIBLE PARTY (GUARANTOR) NAME																																																																																									
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SPECIMEN SOURCE																																																																																									
IF PREGNANCY RELATED SERVICE: PREGNANT Y / N , LMP					ESTIMATED DUE DATE																																																																																				
Results will be immediately available to the patient unless the box is checked <input type="checkbox"/> Do not release (I reasonably believe that an Information Blocking exception applies)																																																																																									
REFERRING LABORATORY/PHYSICIAN (CLIENT) INFORMATION																																																																																									
NAME					PHONE			FAX																																																																																	
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	ADDRESS				CITY		STATE	ZIP																																																																																	
BILLING INFORMATION																																																																																									
SELECT <u>ONE</u> BILLING METHOD <i>Billing is done in accordance with the information provided below and OHSU Policy. Appropriate areas must be completed or referring laboratory/physician will be billed.</i>																																																																																									
<input type="checkbox"/>	REFERRING LABORATORY / PHYSICIAN (CLIENT):																																																																																								
<input type="checkbox"/>	INDUSTRIAL ACCOUNT NUMBER:																																																																																								
<input type="checkbox"/>	PATIENT OR INSURANCE ***ATTACH COPY OF INSURANCE CARD*** <table border="1"> <thead> <tr> <th colspan="5">PRIMARY</th> <th colspan="5">SECONDARY</th> </tr> </thead> <tbody> <tr> <td colspan="5">PREAUTHORIZATION NUMBER</td> <td colspan="5">PREAUTHORIZATION NUMBER</td> </tr> <tr> <td colspan="5">INSURANCE COMPANY</td> <td colspan="5">INSURANCE COMPANY</td> </tr> <tr> <td colspan="3">POLICY NUMBER</td> <td colspan="2">GROUP NUMBER</td> <td colspan="5">POLICY NUMBER GROUP NUMBER</td> </tr> <tr> <td colspan="5">ADDRESS</td> <td colspan="5">ADDRESS</td> </tr> <tr> <td colspan="3">CITY</td> <td>STATE</td> <td>ZIP</td> <td colspan="3">CITY</td> <td>STATE</td> <td>ZIP</td> </tr> <tr> <td colspan="5">PHONE</td> <td colspan="5">PHONE</td> </tr> <tr> <td colspan="3">SUBSCRIBER NAME</td> <td>DOB</td> <td>SEX</td> <td colspan="3">SUBSCRIBER NAME</td> <td>DOB</td> <td>SEX</td> </tr> </tbody> </table>									PRIMARY					SECONDARY					PREAUTHORIZATION NUMBER					PREAUTHORIZATION NUMBER					INSURANCE COMPANY					INSURANCE COMPANY					POLICY NUMBER			GROUP NUMBER		POLICY NUMBER GROUP NUMBER					ADDRESS					ADDRESS					CITY			STATE	ZIP	CITY			STATE	ZIP	PHONE					PHONE					SUBSCRIBER NAME			DOB	SEX	SUBSCRIBER NAME			DOB	SEX
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LAB MEDICINE PH: 503-494-7383 3181 SW Sam Jackson Park Rd HRC9- Portland, OR 97239 F FAX Completed Requisition to: 503-494-6830																																																																																									