VIRGINIA MASON Medical Center

C6-LAB
1100 Ninth Ave., P.O. Box 900, Seattle, WA 98111
(206) 223-6701

LABORATORY REQUEST

VM CLIENT NO. _____

PHONE NO. _____

DATE _____

REFERRING INSTITUTION & ADDRESS _____

ORDERING PHYSICIAN _____

VM PHYSICIAN (IF APPLICABLE) _____

SAMPLE INFORMATION

NAME	SPECIMEN TYPE
BIRTHDATE	REFERRING INST. SPEC. I.D.
SEX	DATE COLLECTED
SOC. SEC. NO.	DIAGNOSIS

BILLING INFORMATION

BILL TO ☐ VM CLIENT NO.

Complete applicable information below. If incomplete, charges will be billed to referring institution client no.

☐ OTHER (SPECIFY) _____
☐ PATIENT
☐ MEDICARE Virginia Mason cannot directly bill hospital in-patients insured by Medicare, Medicaid or Champus.

PT ADDRESS		INSURANCE CO.
CITY		GROUP / SUBSCRIBER NO.
STATE	ZIP	MEDICARE PROVIDER NO.
PHONE		UPIN NO.

TESTS REQUESTS AND ADDITIONAL HISTORY

___ year of transplant
___ suspect acute rejection
___ suspect chronic rejection
___ suspect ATN

All shaded areas are required. Failure to complete above information may result in unnecessary delays in processing of specimen.

SEND REPORT TO (ADDRESS)

(1.)

(2.)

VMMC USE ONLY
RECEIVED _____
CLINIC NO. _____
ACC. NO. _____

VMMC COPY

VMMC 94523 (3/99)