Physician Request for Lab Orders

Patient Name: **Patient DOB:**

Diagnosis:

Lab Test(s) Ordered (If indicated, frequency and duration):

1.

2.

3.

4.

5.

6.

Note: If this is for a dermatologist, Please be aware that we perform Qualitative HCG (Positive/Negative), a quantitative HCG will be sent to a reference laboratory.

Ordering Provider Signature:

Ordering Provider Printed Name:

Ordering Provider Address: **Phone Number:** **Fax Number:** **E-Mail Address**

Ordering Provider NPI:

Fax your completed form to (479) 575-7787 or Email to pwhclab1@uark.edu

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Pat Walker Health Center

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ATTENTION: The information requested on this form is critical to complete your patient's lab work. Incomplete forms will not be processed. Please include your contact information in case we have questions.