STANFORD
UNIVERSITY
MEDICAL CENTER
Stanford Hospital and Clinics
Lucile Packard Children's Hospital

ADD-ON TEST REQUEST FORM/ VERBAL ORDER VERIFICATION

Use this form to request additional testing on specimens that you have previously submitted to **Stanford/Packard** lab or for verbal order verification. Please provide all requested information and fax to 650-724-4758. A lab assistant will transfer the demographic and insurance information from your original test order or contact you if additional sample is required.

NOTE: Please order only those tests that you believe are appropriate for each patient. You must document the need for each test by entering ICD-9 codes, to the highest degree of specificity, in the Diagnosis section of this form. When ordering tests for which Medicare reimbursement will be sought, only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes, Any request to add on Limited Coverage Testing that is not supported by a diagnosis validating medical necessity must be accompanied by an Advance Beneficiary Notice(ABN) properly executed by the patient.

TODAYS DATE:_____

REFERRING PHYSICIAN:_____ CS LOC #_____

NAME AND TITLE OF PERSON CALLING IN ORDER:
_____

PATIENTS NAME:_____

DATE OF ORIGINAL ORDER:_____
(FOR ADD-ON ORDERS ONLY)

ORIGINAL ACCESSION NUMBER:_____
(FOR ADD-ON ORDERS ONLY)

ICD-9 CODE(S):_____ _____ _____ _____ _____

TEST CODE	**NAME OF TEST ORDERED**
_____	_____
_____	_____
_____	_____

SIGNATURE OF REFERRING PHYSICIAN OR AUTHORIZED DESIGNEE:_____

NAME OF OFFICE CONTACT:_____

Please fax completed form to: 650-724-4758