

Beth Israel Deaconess Medical Center
330 Brookline Avenue
Boston, MA 02215

ADDITIONAL TEST (ADD-ON) REQUEST FORM

This form must be filled out completely in order to process your request.

FAX to (617) 667-1533
Call Customer Service at (617) 667-LABS with questions.

Patient Name _____ BI # _____

Your Account Name _____ FAX # _____

Original Date of Specimen _____ Specimen Type (circle one): Urine/Blood/Other

TEST(S) TO BE ADDED

IMPORTANT: HIV Testing *cannot* be added

TEST NAME: _____ Dx (ICD9) Code: _____

TEST NAME: _____ Dx (ICD9) Code: _____

TEST NAME: _____ Dx (ICD9) Code: _____

TEST AUTHORIZATION - Please sign and date below

NAME: _____ DATE: _____
(PLEASE PRINT)

SIGNATURE: _____

BIDMC stores specimens for 7 days from receipt in the laboratory.
You will be notified if the additional testing cannot be processed.
Please be advised that add-ons may take 24 hours to process.