

REQUEST FOR ADD-ON TESTING

The United States Code of Federal Regulations Requires a Written and Signed Request Be Forwarded To Our Laboratory When Additional Testing Is Requested.

FOR PHYSICIAN USE
PLEASE COMPLETE ALL BOLD FIELDS

Account Number: _____

Patient Name: _____

Account Name: _____

D.O.B. _____

Specimen Number/Bar Code: _____

Test Number/Numbers: _____

Test Name/Names: _____

Specimen Date: _____ **Dx. Code:** _____ **Medicare Patient? Yes** **No**

Office Fax Number: _____

SIGNATURE OF PHYSICIAN (OR AUTHORIZED DESIGNEE)

DATE _____

TIME _____

FAX COMPLETED FORM TO:

LUMINA CLIENT SERVICES DEPT

Please check here if you would like fax confirmation that request has been received and is in process
Please be advised that you will be notified via fax if we are unable to process your add-on request.

FOR LUMINA USE ONLY

Test could not be added:

Quantity not sufficient _____

Already discarded _____

Too old for viable results _____

Other: _____

Depending upon the type of specimen, samples are usually held from 2-10 days.

FORM MUST BE COMPLETED IN ITS ENTIRETY OR PROCESSING OF REQUEST

This document contains private and confidential health information protected by State and Federal Law.
If you have received this document in error, please call 973-830-8900.