MUNSON MEDICAL CENTER

Form # 0975 (02/19)

OUTPATIENT LABORATORY REQUISITION

TODAY'S DATE:

PATIENT LEGAL NAME-LAST	FIRST	MIDDLE INITIAL

BIRTHDATE	SEX	STAT	
	☐ M ☐ F	☐ Also check Phone or Fax	☐ PHONE results to: OR ☐ FAX results to:

RECOMMENDED COLLECT DATE & TIME	STANDING ORDER FREQUENCY:
	☐ Weekly ☐ Monthly ☐ As Needed ☐ Other

DIAGNOSIS - (MEDICALLY NECESSARY) SIGNS / SYMPTOMS:

Provider Name:

Practice Address:

Provider Signature: Date:

Copy Report To:

Microbiology

Tests Requested:

- ☐ Influenza A and B
- ☐ COVID-19