

TO:	
DATE:	
PATIENT:	
STATE HEALTH DEPT NO:	
ORIGINAL TEST REQUEST:	

We recently received a telephone request from your office regarding the above specimen requesting that we perform the following additional test(s):


In accordance with 42CFR Part 493 (CLIA), all telephone requests for clinical laboratory tests must be followed up in writing within thirty (30) days.

Please sign in the space below acknowledging that this information is correct and return to the laboratory by faxing to (802) 863-7632.

Thank you for your cooperation.

HEALTH CARE PROVIDER (OR DESIGNEE)	
PRINTED NAME:	
SIGNATURE:	
DATE:	