REV. 09-25-2020
220.LAB.7

ADD-ON REQUEST FORM

2 KENNEDY BOULEVARD, EAST BRUNSWICK, NJ 08816
TEL: 732-777-2588 OR 855-ACULABS
FAX: 732-777-2640
WWW.ACULABS.COM

ACCESSION #_____

PLACE LABEL HERE
(FOR IN HOUSE USE ONLY)

ATT: DATA ENTRY DEPARTMENT

NOTE: ADD-ON REQUESTS FOR URINE AND/OR STOOL CANNOT BE PROCESSED. A NEW REQUISITION FORM MUST BE COMPLETED AND A NEW SAMPLE MUST BE COLLECTED AND SENT TO THE LAB.

ORIGINAL ORDER DATE: _____ **ADD-ON REQUEST DATE:** _____

(**ADD-ON DATE CANNOT BE MORE THAN 24 HOURS AFTER ORIGINAL ORDER DATE**)

FACILITY: _____ **UNIT:** _____

PATIENT'S FULL NAME: _____ **D.O.B.:** _____

TESTS TO BE ADDED:

TEST(S)	ICD-10 (DIAGNOSIS)	TEST(S)	ICD-10 (DIAGNOSIS)

A physician or someone acting on his/her behalf must authorize any test(s) added to a specimen currently at the laboratory for processing. Your signature below indicates that the test(s) requested to add-on are medically necessary. All information must be completely filled out in order to process request.

PRINT FULL NAME: _____ **SIGNATURE:** _____

DATE: _____ **TIME:** _____ **CONTACT NUMBER:** _____

*****POLICY: ADD-ON REQUESTS SUBMITTED MORE THAN 24 HOURS AFTER ORIGINAL ORDER DATE CANNOT BE PROCESSED*****