INFINITY
Diagnostic Laboratories

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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:_____ **Account Name:**_____

Patient 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: 201-365-6068 IDL 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 you add-on request.

FOR IDL 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 FOR PROCESSING OF REQUEST