OHSUHealth
Hillsboro Medical Center

# LABORATORY TESTING REQUISITION

## PATIENT INFORMATION

| PATIENT LAST NAME | FIRST | MI | SEX | DATE OF BIRTH | HOSPITAL STATUS |
|---|---|---|---|---|---|
| | | | | | □ Inpatient<br>□ Oupatient<br>□ Non-Hospital |

| LABORATORY ACCESSION NO./PATIENT IDENTIFICATION NO. | DATE COLLECTED | TIME COLLECTED |
|---|---|---|
| | | |

| RESPONSIBLE PARTY (GUARANTOR) NAME | | | |
|---|---|---|---|
| SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | DATE OF BIRTH | SEX |
| | | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

## TESTING INFORMATION

| TEST NAME(S) | *REQUIRED* ICD-10 DIAGNOSIS CODE(S) AND DESCRIPTION |
|---|---|
| SPECIMEN SOURCE | Results will be immediately available to the patient unless you mark the box below:<br>□ *Do not release* (I reasonably believe that an Information Blocking Exception applies). |

## REFERRING LABORATORY/PHYSICIAN (CLIENT) INFORMATION

| NAME | PHONE | FAX |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| REQUESTING PHYSICIAN | NPI (REQUIRED BY MEDICARE) | PHONE |
|---|---|---|
| | | |

| ADDITIONAL (CC) REPORT TO | FAX |
|---|---|
| | |

## BILLING INFORMATION

SELECT ONE BILLING METHOD

Billing is done in accordance with the information provided below and HMC policy. Appropriate areas must be completed or referring laboratory/physician will be billed.

☐ REFERRING LABORATORY/PHYSICIAN (CLIENT)

☐ PATIENT OR INSURANCE **ATTACH COPY OF CARD**

PRIMARY:
ID#: GRP#:
ADDRESS:

PHONE:
SUBSCRIBER NAME: DOB: SEX:

SECONDARY:
ID#: GRP#:
ADDRESS:

PHONE:
SUBSCRIBER NAME: DOB: SEX:

## LABORATORY CONTACT INFO

**Client Services: PH (503) 681-1140 FAX (503) 681-4113**
Pathology: PH (503) 681-1147 FAX (503) 681-1903
Main Hospital Laboratory: 335 SE 8th Avenue, Hillsboro, OR 97123
**7th Avenue Outpatient Draw Station: 333 SE 7th Avenue 3rd floor, Hillsboro, OR 97123**
**(Draw station hours M-F 7:00am-5:00pm. Register on 1st floor prior to draw)**