

# Cleveland Clinic Laboratories

## Authorization for Test Add Request

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Client Name: \_\_\_\_\_ Client Code: \_\_\_\_\_

Attention: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Client Address: \_\_\_\_\_  
Street Address City State Zip Code

A request for an additional test was made to this laboratory for a patient who you previously submitted specimens and a requisition for. Due to federal regulations, (Federal Register, February 1992), verbal requests for laboratory orders are permitted only if a laboratory subsequently obtains written authorization for testing within 30 days of the request. Please provide the information requested below to indicate these additional tests were requested by you or your representative. In addition, please document these additional laboratory orders in the patient's chart and/or other appropriate laboratory records, which you maintain.

Name of Requestor: \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Accession #: \_\_\_\_\_

Collection Date/Time: \_\_\_\_\_ Specimen Type: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

### TESTS/ADDITIONAL TESTS REQUESTED:

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Tech accepting verbal request: \_\_\_\_\_ Date: \_\_\_\_\_

Authorizing Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Primary Physician or Authorized Representative)*

**Return this completed form to the address listed above or fax to 216.444.0460.**

Processed by Client Services: \_\_\_\_\_

**Submit completed document for archiving.**