COMPLETE HEALTH FIRST	854 Kearny Ave. Unit 2 Kearny, NJ 07032 Tel: (201) 428-1162	**Blood Test Requisition** **In Home Service** **Fax: 201-428-1375**

PROVIDER INFORMATION

PHYSICIAN: _____ **PHONE**: _____ **FAX**: _____

NPI: _____ **ADDRESS**: _____ **CITY**: _____ **STATE**: _____ **ZIP**: _____

PATIENT INFORMATION

LAST _____ **M** _____ **FIRST** _____ **[ ] M [ ] F**

D.O.B (MM/DD/YY) _____/_____/_____ **SSN** ____.____._____ **PHONE** ( ) _____-_____

ADRESS: _____ **CITY** _____ **STATE** _____ **ZIP** _____

INSURANCE

INSURED'S NAME (if different from patient) _____

PRIMARY INSURANCE NAME & PLAN _____ **POLICY I.D.#** _____

ADDRESS: (Insurance) _____

ICD-10 CODES/ DIAGNOSIS

STAMP:

	NOTES:

TEST

[ ] PTT	**[ ] TSH**	**[ ] CHOLESTEROL**
[ ] PT/iNR	**[ ] T3, FREE**	**[ ] CRP-HS (CARDIAC)**
[ ] BMP	**[ ] T3, UPTAKE**	**[ ] HEMOGLOBIN A1C**
[ ] CMP	**[ ] T3, TOTAL**	**[ ] MAGNESIUM**
[ ] CBC	**[ ] T4, FREE**	**[ ] POTASSIUM**
[ ] LIPID PROFILE	**[ ] T4, TOTAL**	**[ ] DIGOXIN LEVEL**
[ ] IRON & TIBC	**[ ] HEP A,B,C,PANEL**	**[ ] DILANTIN**
[ ] VITAMIN D-25	**[ ] URINE CULTURE**	**[ ] VALPROIC ACID**
[ ] VITAMIN B-12/ FOLATE	**[ ] URINALYSIS**	**[ ] PSA, FREE & TOTAL**
[ ] ALLERGY PANEL	**[ ] HOMOCYSTEINE**	**[ ] ANEMIA PROFILE**

OTHER TEST:

DATE TO BE COLLECTED: ____/____/_____ TIME _____ [ ] **STAT** **[] FASTING** **[] NON FASTING**

REDRAW ORDER: [] DAILY [] WEEKLY [] MONTHLY [] OTHER

LENGTH OF SERVICE: One _____ Two _____ Three_____ Four _____ Five _____ Six _____ Seven _____ Eight _____

OTHER _____

PROVIDER SIGNATURE _____ **DATE** _____/_____/20_____