Approval Request for Sendout Testing

NewYork-Presbyterian Hospital/Columbia University Medical Center

TO BE COMPLETED BY REQUESTING PHYSICIAN; PLEASE PRINT CLEARLY

Requesting Physician Information

Name: _____ **Pager/Phone #:** _____

Test Information:

Assay Name: _____

Suggested Laboratory (opt.):_____ **Test Code (opt.):** _____

Patient Information:

Name: _____ **MRN:** _____

Location:_____

Pertinent Clinical History:

Explanation of Clinical Utility of the Test and of Specific Laboratory Suggested:

Requesting Attending Name: _____

Requesting Attending Signature: _____**Date:** _____

NOTE: If the desired test is not available through a laboratory that is NY State approved for that test, you must fill out and enclose the *NYS NON-Permitted Laboratory Test Request Approval Form,* available at
http://www.wadsworth.org/labcert/clep/Administrative/nonpermittedappins.pdf

Test NYS Approved : Y N Appropriate Paperwork Attached: Y N N/A

Please fax completed form(s) to 646-426-0065; for any questions, please contact the Core Laboratory Resident (pager 8-7055).