ECU
STUDENT HEALTH SERVICES

Outside Lab Order
ALL INFORMATION IS REQUIRED

Patient Last Name:_____ First Name:_____ MI:_____

Date of Birth: _____/_____/_____Banner ID # _____

Address: _____
              Street   City   State   Zip

COPY OF INSURANCE CARD AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION IS REQUIRED ALONG WITH ALL LAB ORDER INFO BELOW
SHS cannot contact the patient to schedule the lab appointment without all fields below complete.

IT IS THE RESPONSIBILITY OF THE ORDERING OFFICE TO ENSURE RESULTS ARE RECEIVED BY THEIR OFFICE and that the patient receives appropriate follow up.

Ordering provider name:	
Ordering provider full mailing address:	
Ordering provider phone/fax number:	Phone: ( ) Fax: ( )
ICD-10 Code(s) for reason for testing:	
Requested lab test(s) NAME and frequency. LOINC codes are NOT acceptable. You may use LabCorp order numbers. Must have EITHER test name or LabCorp order number.	☐ One time order ☐ Recurring order frequency_____ *orders expire 6 months from receipt of form. If recurring labs are needed longer additional orders will be required.*
Ordering provider instructions for the patient regarding follow up	
Ordering provider signature	

Please fax to (252) 328-0462 or email to shsmedfax@ecu.edu to ensure we have all the required information.

Failure to provide **ALL** required information will result in lab testing being delayed.