DRO07

METHODIST HEALTH SYSTEM

LAB ORDERS
Today's Date: _____

Date to be Drawn: _____

For Lab Use Only:
Verbal Order received by: _____

Date and Time: _____

Faxed for signature by: _____

Patient Instructions:

Three Specimen Collection Locations Available

Methodist Hospital Admitting
8303 Dodge Street
North Tower, First Floor
Omaha, NE 68114
Hours: 7:00a.m. - 5:00p.m. Mon–Fri
7:30a.m. - 2:00p.m. Saturday
Phone: 402 – 354 – 4540
Fax: 402 – 354 – 6149

Methodist W. Dodge Medical Plz
515 North 162nd Avenue
First Floor, Suite 100
Omaha, NE 68118
Hours: 7:30a.m. – 4:00p.m. Mon–Fri
NO Weekend Hours
Phone: 402 – 354 – 7329
Fax: 402 – 354 – 7333

Methodist Women's Hospital
707 North 190th Plaza
First Floor, Radiology
Omaha, NE 68022
Hours: 7:30a.m. – 4:00p.m. Mon–Fri
Phone: 402 – 815 – 4344
Fax: 402 – 815 – 1365
Weekend Fax: 402-815-1470

(Patient ID label May Be Used Here)

Patient Legal Name: _____ _____/_____/_____
LAST **FIRST** **MI** **Date of Birth**

Please Print First and Last Name
Ordering Provider: _____ **Office Phone:** _____ **Fax:** _____
LAST **FIRST**

Order Written By: _____ **Nursing Unit:** **Phone #:**

Tests ordered **MUST** include an appropriate signs, symptoms, ICD-9 code, or narrative diagnosis specific to each test ordered

TEST	**REASON for TESTING (ICD-9)**

Special Instructions for Laboratory: _____

Physician / Authorized Signature: _____ **Date:** **Time:**

Please remember when ordering laboratory tests that are billed to Medicare/Medicaid, or other federally funded programs that only tests that are medically necessary for the diagnosis or treatment of the patient should be ordered. Medicare does not pay for screening testing except for certain, specifically approved procedures and may not pay for non-FDA approved tests or those tests considered experimental.