REQUEST FOR CLINICAL LAB REQUISITION FORM

***Please include a copy of the IRB Letter of Approval and any special instructions, specimen requirements, and/or send-out instructions upon submission of this form.****

Today’s Date: _____________________

Study Name: _________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Stanford Project Director/Investigator/Physician’s Name: ________________________

Primary Diagnosis Code (Example: Z00.00): ___________________________________

Dept. Name: ___________________________________________

Contact Person: ______________________    _____           Phone Number:      __________________________

Duration of Study: Start Date: _ ________________   Anticipated End Date: ____________________

Frequency of Specimens: _______________________________________________________________________

Who Will Collect the Specimens: _________________________________________________________________

Number of Patients in Study: ___________________________________________________________________

Are they Inpatients or Outpatients:  ______________________________________________________________

Account Number: _____________________________________________________________________________
(Is this to be Billed to the Patient, an 80098 number, or mnemonic account?)

Will the Laboratory be doing the Testing? _________________________________________________________

If so, please specify which tests you are requesting:
_____________________________________________________________________________________________
_____________________________________________________________________________________________

If not, at which lab will tests be done? ____________________________________________________________

Should the patient’s medical record number appear on the report? Should it be Identified or de-Identified?
________________________________________________________

If not what code name(s) will you be using? _______________________________________________________

________________________________________________________

I have read and agree to the above statement: ________________________________

PLEASE RETURN THIS FORM TO: Ester Magoncia~ (FAX) 650-723-6752; email:
emagoncia@stanfordhealthcare.org

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