CLIENT/PATIENT REFERRAL FORM

Office: 760-745-1713 - Toll: 877-670-VENI (8364)

Please fax all referrals to: 877-626-2306

Patient Name: ____________________

Gender: Male: ☐ Female: ☐ | Patient DOB: ____________

Phone #: ____________________

Address: ____________________

MRN # : ____________________

Patient Insurance: ____________________

Policy # ____________________

Ordering Physician :		NPI:
Ordering Physician Phone #:		FAX #:
Referring Source:		
Referring Source Phone #:		FAX #:
Type of Service:	Venipuncture: ☐ Fingerstick: ☐ Specimen Pickup: ☐	
Requested Date:	Requested Time:	Urgency: Routine ☐ Urgent ☐ STAT ☐

Lab Tests Needed:		Diagnosis Codes:		Preferred Lab:

How do we Bill:	Bill Patient ☐ Bill Referring Source ☐ Bill Insurance ☐
	Special Remarks:

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