MARSHALL ORTHOPAEDICS

GOOD SHEPHERD MEDICAL CENTER – MARSHALL MARSHALL, TEXAS

OUTPATIENT LAB ORDER FORM

PATIENT NAME:

SS NUMBER:

DATE OF BIRTH: SEX:

ORDERING PHYSICIAN: **please fax results to 903-935-0077**

DIAGNOSIS:

LAB STUDY:

for specimen collection…..

DATE / TIME:

SOURCE:

____

(please attach copy of Marshall Ortho demographic sheet and both sides of insurance card)

I consent to the performance and administration of the above-cited outpatient services by Good Shepherd Medical Center – Marshall.

_____________________________ ______________________________________

Signature Date / Time

_________________________________ _______________________________

Relationship to Patient Witness

PLEASE FAX RESULTS TO 903-935-0077