Request for Standing Orders

Fax to: 805-692-4611

To comply with Federal and State regulations we need the following information to draw your patient on a repetitive basis. The order will not be considered valid or processed until all required fields are complete.

Patient Name: ______________________________ DOB : __________________

Patient ID #:________________ (optional) Copy to Patient: ☐

Order Start Date:___________________ Order End Date:___________________

Frequency must be specific (**NO PRN**). For example: daily, weekly, bi-weekly or monthly. The period of the Standing Order cannot exceed 12 month. Pacific Diagnostic Laboratory will be sending you a renewal before the Standing Order will expire. At that time you can elect to continue, change or cancel the patient's order.

Ordering Physician:_________________ Client #:_______________________

Phone: __________________________ Fax: __________________________

Test Name	Frequency	Diagnosis/ICD9	Test Code (internal use)	ABN (internal use)

AUTHORIZING SIGNATURE ________________________ DATE______________

(Written authorization is required for all laboratory tests ordered)