LAB TESTING REQUISITION

TRIDENT LABORATORIES

Trident Labs, LLC
242 Howard Ave., Suite 207
Holland, MI 49424
phone: 855.875.2532
fax: 616.233.9304

Run ID: _____

Client:

Last Name: _____ First Name: _____

Patient DOB: _____ SSN: _____

Male: ☐ Female: ☐

Requesting Provider:

PLEASE ATTATCH COPY OF PATIENT DEMOGRAPHICS

Date Collected: _____ / _____ / _____

Diagnosis Code(s)

Provider Signature: _____

____ V58.69	____ 292.0	____ 295.90	____ 296.01
____ 296.3	____ 296.90	____ 296.91	____ 300.0
____ 304.0	____ 304.9	____ 311	____ 338.4
____ 724.2	____ 724.4	_____ _____	_____ Other

☐ Run test per Standing Order

☐ Special instructions: _____

_____ _____

CURRENT PRESCRIBED MEDICATIONS (PLEASE ATTATCH A CURRNT MEDICATION LIST WITH THIS FORM)

_____ ACTIC (FENTANYL)	_____ LORAZEPAM (ATIVAN)	_____ NUCYNTA (TAPENTADOL)
_____ ALPRAZOLAM (XANAX)296.3	_____ LORTAB (HYDROCODONE)	_____ OPANA (OXYMORPHONE)
_____ CODIENE (TYLENOL 3, 4)	_____ METHADONE (DOLOPHINE)	_____ OXYCONTIN (OXYCODONE)
_____ DILUADID (HYDROMORPHONE)	_____ MS CONTIN (MORPHINE)	_____ PERCOCET (OXYCODONE)
_____ DURAGESIC (FENTANYL)	_____ MEPERIDINE (DEMEROL)	_____ PREGABLIN (LYRICA)
_____ HYDROCODONE (LORCET)	_____ NAPROXEN (NAPROSYN)	_____ PROPOXYPHENE (DARVOCET)
_____ KADIAN (MORPHINE)	_____ NEURONTIN (GABAPENTIN)	_____ OTHER _____
_____ ZANAFLEX (TIZANIDINE)	_____ NORCO (HYDROCODONE)	_____ NO PRESCRIBED MEDICATION

PLEASE ATTATCH A COPY OF THE FRONT AND BACK OF RESPONSIBLE PARTY'S INSURANCE CARD(S)

Payment Information: ___ Insurance ___ Private Pay ___ Workers Comp ___ Medicare/Medicaid

INSURANCE COMPANY:	
Group #:	
Subscriber Name:	

AUTHORIZATION FOR TRIDENT LABS, LLC TO BILL FOR PATIENT'S INSURANCE BENEFITS

I authorize the release of any and all medical information necessary to process my medical service claims. I permit a copy of the authorization to be used in place of the original. I hereby authorize Trident Labs to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly toe Trident Labs, LLC. If I have Medicare insurance, I authorize Trident Labs, LLC to release to the Social Security and Care Financing Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid until revoked by myself or Trident Labs, LLC by written request.

Patients Signature: _____ **Date:** _____

SPECIMEN ID NO. 

_____ Donor's Initials

SPECIMEN BOTTLE SEAL

__/__/__ Date (Mo/Day/Yr)