

**UT HEALTH NORTH CAMPUS PATHOLOGY /MICROBIOLOGY**

**CAP # 20793-01; CLIA # 45D0483716**

**SHIP SPECIMENS (NOT ISOLATES) TO:**

**UT HEALTH NORTH CAMPUS Pathology/Microbiology**

**11937 US Hwy 271**

**Tyler, Texas 75708-3154**

**Phone: 903-877-5745 FAX 903-877-2816**

**MAKE ALL CHECKS PAYABLE TO: UT HEALTH NORTH CAMPUS**

A doctor's signature is required at the bottom of this form.

Name\* \_\_\_\_\_ DOB\* \_\_\_\_\_ Sex \_\_\_\_\_  
Last First

Specimen # \_\_\_\_\_ \*Social Security # \_\_\_\_\_ Race \_\_\_\_\_

Clinical Diagnosis/HX/\*ICD 9 CODE(s)

**\*Source of Specimen:**

What organisms are you suspecting to grow if any?

**\*Specimen Collection Date:**

MYCOBACTERIA CULTURE? Y / N Order Code:

MYCOBACTERIA SENSITIVITY? Y / N Order Code:

FUNGAL / MYCOLOGY CULTURE? Y / N Order Code:

AEROBIC / BACTERIAL CULTURE? Y / N Order Code:

If anything grows from cultures, there are separate charges for ID and sensitivity

Special Instructions:

**\*REQUIRED INFORMATION FOR INSURANCE PURPOSES**

**REPORT TO BE SENT TO:**

NAME: PHONE:

ADDRESS: FAX:

**BILLING ADDRESS/INSURANCE INFORMATION; Attach insurance photocopy & a copy of physician test order (this is mandatory). Note: Physician is responsible for "out of network" charges. We do NOT accept out of state medicaid insurance.**

NAME: PHONE:

ADDRESS: FAX:

**ATTENDING/ORDERING PHYSICIAN**

NAME: PHONE:

ADDRESS: FAX:

PHYSICIAN SIGNATURE REQUIRED:

7/16/18