MANKATO CLINIC LABORATORY

Name of Facility________________________

Lab Draw Date: ________________________

(for lab use only)

Name/Room	DOB	ORDERING PROVIDER	Is this billed under Medicare A or Medicare B	TESTS	DIAGNOSIS	COMMENTS	O	T	L	E

***Please fax to: 507-625-8012 (507-934-0012 if located in St. Peter) by noon the day before your schedule lab day.**

MC1810 (03/18)