Mankato Clinic
Extended Care

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 this completed form to: 507-625-8012 by noon the day before your scheduled lab day.**

St. Peter facilities fax to 507-934-0012. Mapleton facilities to 507-524-4991.

MC1810 (02/2026)