



Med Tech Clinical Laboratory, Inc.

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TELEPHONE REQUEST CONFIRMATION/ADD ON TEST

Date: _____

To: _____

From: _____

Per your telephone request, the following test(s) were performed for your patient. To comply with current regulations, please confirm your request by signing below, and include the ICD-9 code.

Please return this form to Med Tech Clinical lab within 24 hours.
Thank you.

Patient Name: _____

Test: _____

Signature of Physician: _____

ICD-9 Code: _____