New Physician / Account

Patient Information (Mandatory)

This Form Filled Out By:		Date:
Patient Name:		DOB:
MRN:	Order #:	DOS:

Physician Information

Physicians Last Name:	Physician First Name, MI:	☐ MD ☐DO ☐ NP ☐PA
Practice Name:		

Notes

Address for Reports

Street:		
City:	State:	Zip:
Telephone:	Fax:	

Fax Completed Form to Lisa Denman @ 517-372-5540 or Email: lab@sparrow.org

For Computer Room Use Only

Epic #:	Soft #:		Area:
Ward/Clinic:	Report: Printer EMR Labtest Autofax R(Paper Copy)		
NPI #:		Labtest STO/OTO	
Entered by:	Taxonomy Code:	Date:	Resent to HIS:

WindoPath		
Entered by:	Double Check:	Added to Case:
Compliance Exclusion Check completed by:		Date:

Revised 11/1/2023 sal/caw