



Ambulatory Surgery Unit  
325 West 15<sup>th</sup> Street, New York, NY 10011  
Tel. No. (212) 604-6070

Please fax this form to **both** locations  
Lab (212) 604-6063 and  
Registration (212) 604-6099

**Pre-Admission Testing  
Lab Request Form and Registration Form**

**DOCTOR:** \_\_\_\_\_

**PATIENT**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_ TIME OF SURGERY: \_\_\_\_\_ AM / PM

PROCEDURE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

**PRE-SURGICAL TESTING:**

- |   |  |
|---|--|
| <input type="checkbox"/> CBC                    | <input type="checkbox"/> ECG               |
| <input type="checkbox"/> Basic Metabolic        | <input type="checkbox"/> Chest X-ray       |
| <input type="checkbox"/> Hepatic Profile        | <input type="checkbox"/> Medical Clearance |
| <input type="checkbox"/> PT / PTT               | Other _____                                |
| <input type="checkbox"/> Glucose                | _____                                      |
| <input type="checkbox"/> Urinalysis             |  |
| <input type="checkbox"/> Urine – Pregnancy Test |  |

**PATIENT ADDRESS:** \_\_\_\_\_

TELEPHONE: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

CELLULAR: \_\_\_\_\_ OTHERS: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

PRE-CERTIFIED / BY WHOM: \_\_\_\_\_

BOOKED BY: \_\_\_\_\_ TEL. NO. \_\_\_\_\_

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