PHOENIX CHILDREN'S *Hospital*®

# LABORATORY SWEAT CHLORIDE TEST REQUEST

Apply Patient Label

Patient Name: _____ Date of Birth: _____

Address: _____ Male ☐ Female ☐

_____

Home Phone _____

Diagnosis _____ ICD-9 code _____

Insurance Company _____ ID#: _____

Authorization Number _____ group# _____

Ordering Physician _____ Physician Phone _____

Physician Fax _____

Physician Address _____

_____

Physician Signature _____ Date & Time _____

→ THESE TESTS MUST BE SCHEDULED IN ADVANCE WITH THE PCH OUTPATIENT LABORATORY 602-933-0314

→ THIS FORM MUST BE FAXED TO (602) 933-0327

NOTE: Diagnosis/ICD-9, Insurance Authorization and Physician's Signature are required before testing can be performed.

CPT Codes: 89230, 82438