

SERUM IOTHALAMATE REQUISITION

Columbia University Irving Medical Center

Clinical Pharmacology and Toxicology Laboratory
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New York, NY 10032

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PFI: 8006
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PLEASE TYPE/PRINT

Patient Name (Last Name, First Name): _____

Patient Date of Birth (MM-DD-YYYY): _____

Patient Gender: _____

Sample Collection Date and Time: _____

Hospital/Institution Name: _____

Healthcare Provider Name: _____

Healthcare Provider Signature: _____

Healthcare Provider E-mail or Fax: _____
(Required for results reporting)

For Laboratory Use Only:

Date and time specimen receipt: _____

Accession number: _____