

RETEST REQUEST FORM

ACCOUNT INFORMATION

_____	_____	_____
Account Number	Contact Name	Contact Title
_____	_____	_____
Date	Phone Number	Email

ACCESSION NUMBER

LIST EACH DRUG OR PANEL TO BE TESTED*

*Testing will be performed according to your agency's testing profile.

ACCOUNT INFORMATION

I understand/acknowledge that appropriate charges will be made for all retest requests.	
_____	_____
Printed Name	Signature (Required)
Please fax completed form back to Client Services at 707-577-0365.	

