Correlation testing request

Allina Health LABORATORY

Client Information

Date:
Clinic/Facility name: Collection Center Code:
Contact name:
Contact phone #: Contact fax #:
☐ Allina Health facility *or* ☐ Outreach client

Account Rep:
☐ Lisa Johnson (612) 863-0475 ☐ Paula Perry (612) 863-0439
☐ Lisa Peterson (612) 863-0443 ☐ Amy Stratton (612) 863-4674

Specimen/Result Information

Test Name/Analyte Requested:

Clinic/Facility Sample ID	Clinic/Facility Results*	Allina Health Laboratory Sample ID	Allina Health Laboratory Results**

*** Include instrument printout whenever possible
**Allina Health Laboratory results may be returned on a separate document

For Allina Health Laboratory Use ONLY

☐ Department fax copy of this completed form to Client Services at x34067 Init/Date:
☐ Client Services fax copy of completed form to client at number indicated above Init/Date:
☐ Client Services email to Billing at labbilling@allina.com Init/Date:
☐ Store document in OnBase as REF- Correlation Testing Init/Date: