LabLink Downtime Form

Allina Health LABORATORY
2800 10th Ave S, Ste 2000 Minneapolis, MN 55407

CLIENT INFORMATION:

Client Code:	Client Name:
Client Address:	
Client Phone:	

PATIENT/SPECIMEN INFORMATION:

Name (Last, First MI)	DOB	Gender: ☐ Male ☐ Female
Address (Street)		
Address (City, state and ZIP)		
Phone #:	Collection date:	Collection time:

PROVIDER INFORMATION:

Name (Last, First MI)	PID or NPI #:

BILL TO: ☐ Clinic/facility ☐ Patient/Insurance

If bill patient/insurance is indicated, complete the following:	
Diagnosis code(s):	
Insurance Co name:	
Policy #:	Group #:
Policy holder name:	Policy holder DOB (if not patient):

TEST INFORMATION:

Test #	Test Name	***Source (if applicable)***	***STAT***

☐ Call results to _____ at _____
☐ Fax results to _____ at _____

For Allina Health Laboratory Use only	
Tube(s) rcv'd: Gold SST ____ Lt Green PST ____ Red____ Dk green ____Transfer____ Frozen____ Swab _____ Formalin _____	Place RQ label here