


NYCWC

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Patient Name:	
Address: _____ _____	Date of Birth: ____/____/____ Telephone: (____) _____

Prior to your appointment please print and date this prescription to take to the lab for blood work. Please be advised that it can take up to 72 hours for the results to be finalized.

Diagnosis: 200.00 Physical Exam		<input checked="" type="checkbox"/> Fasting	<input type="checkbox"/> Non-Fasting
<input checked="" type="checkbox"/> CBC w/Diff (M35.3)	<input checked="" type="checkbox"/> Comprehensive Metabolic Panel (I10)	<input checked="" type="checkbox"/> Lipid Panel (E78.0)	<input checked="" type="checkbox"/> Thyroid Panel(T3, T4, T7, TSH) (E03.9)
<input checked="" type="checkbox"/> HbA1C (E11.9)	<input checked="" type="checkbox"/> Folic Acid (D64.9) **	<input checked="" type="checkbox"/> Urinalysis (N39.0)	<input checked="" type="checkbox"/> Urine Culture (R10.9)
		<input checked="" type="checkbox"/> Vitamin D 25-OH **	<input checked="" type="checkbox"/> PSA (F52.21)
		<input checked="" type="checkbox"/> Vitamin B12 **	
Physician Signature: 		Date: / /	

Please be Advised that tests marked with ** may not be covered by your insurance, it is advised that you check with your insurance carrier prior to having these tests preformed