



## Test Request Form

Transaction Number: 17062

Ship specimens to:  
Mayo Medical Laboratories  
3050 Superior Drive NW  
Rochester, MN 55901  
1-800-533-1710 | 507-266-5700

### Patient Information **Required**

MRN (Patient ID)	Patient Name (Last, First, Middle Initial)		
Birth Date (Month DD, YYYY)	Sex <input type="radio"/> Male <input type="radio"/> Female	Collection Date (Month DD, YYYY)	Time <input type="radio"/> AM <input type="radio"/> PM
Accession No. (Order No.)	Referring Physician Name		Phone (with area code)

### Call Back / Fax Reports To (if required):

Phone Number	Name (Last, First, Middle Initial)
Fax	Name (Last, First, Middle Initial)
Fax	Name (Last, First, Middle Initial)

### Test Requested

Test ID <b>FAPEP</b>	Test Name <b>Fatty Acid Profile, Essential, Serum</b>
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