MAYO CLINIC
Mayo Medical Laboratories

Test Request Form

Transaction Number: 17054

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 ○ Male ○ Female	Collection Date (Month DD, YYYY)	Time ○ AM ○ 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	Test Name
FRT4D	**T4 (Thyroxine), Free by Dialysis, Serum**