UNIVERSITY OF MICHIGAN HEALTH-SPARROW
MICHIGAN MEDICINE

New Provider / Account

Patient Information (Mandatory)

This Form Filled Out By:		Date:
Patient Name:		DOB:
MRN:	Order #:	DOS:

Provider Information

Provider Last Name:	Provider First Name, MI:	☐ MD ☐DO ☐NP ☐PA
Practice Name:		

Notes

Address for Reports

Street:		
City:	State:	Zip:
Telephone:	Fax:	

Send completed form to lab@umhsparrow.org

For Computer Room Use Only

Epic #:	Soft #:	Area:	
Ward/Clinic:	Report: Printer EMR Labtest Autofax R(Paper Copy)		
NPI #:		Labtest STO/OTO	
Entered by:	Taxonomy Code:	Date:	Resent to HIS:
WindoPath			
Entered by:	Double Check:		Added to Case:
Compliance Exclusion Check completed by:			Date:

Revised 06/26/2024 sal