# Outpatient Lab Orders

*VAD Travel Pack*

## Patient Information

Patient's Name:

*First* *Middle* *Last*

DOB: MRN:

*MM / DD / YYYY*

Home Address:

Phone: - - ***Home*** ***Mobile*** ***Other*** ____________

## Hospital Information

Hospital Name:

Hospital Address:

Phone: - - Fax: - -

**FAX LAB RESULTS TO:**

[Hospital Name]
Cardiology/VAD Program
ATTENTION: [Name/Dept]
[Hospital Address]
[City, State, Zip Code]
[Phone/Fax}

## Lab Information

Lab Name:

Lab Address:

Phone: - - Fax: - -

## For Lab Use

**Please draw labs on the following dates:**

**DX:**

## Please draw/run the following labs:

| | |
|---|---|
| *PT & INR* | *LDH* |
| *CBC w/ Diff* | *CRP* |
| *CMP* | *BNP* |

**If INR <1.8 or >3.5 please notify your care team at:**

Notes: