PHARMACY CONSULT

Convergent LABORATORIES

Date: _____

Practice: _____

Address: Address: _____

City: _____ Zip Code: _____

Provider & Patient Contact Info:

Provider's Name: _____

Provider's NPI: _____

Patient's Name: _____

Patients DOB: _____

Patient Allergies: _____

_____

Renal Function: O Normal O Abnormal

Liver Function: O Normal O Abnormal

Comments

_____

_____

FAX or E-MAIL COMPLETED FORM TO: (214) 919-0017 or Consult@ConvergentDX.com