Litholink
LabCorp Specialty Testing Group

Collection Data Form

www.litholink.com
800 338 4333
(M–F, 7:00am–7:00pm CT)

Patient Information *Complete form and return it with your sample(s).*

LAST NAME: FIRST NAME: MI:

ADDRESS:

CITY: STATE: ZIP CODE:

DATE OF BIRTH:

GENDER: (CIRCLE ONE) MALE FEMALE PARENT/GUARDIAN NAME:

PRIMARY PHONE NUMBER: ( ) EMAIL:

Prescribing Physician ☐ I have included my Test Request Form that was given to me by my physician. *(no further Physician Information necessary)*

PHYSICIAN LAST NAME: FIRST NAME: OFFICE PHONE:

Collection 1 (required)

FLUSH TIME = START TIME

START TIME: am

STOP TIME: am

DATE COLLECTION ENDED: / /

TOTAL VOLUME:* ml

**Total Volume equals amount of urine in orange jug.*

Collection 2 (if performed)

Collection 2 start time MUST MATCH Collection 1 Stop time.

START TIME: am

STOP TIME: am

DATE COLLECTION ENDED: / /

TOTAL VOLUME:* ml

Medical History - *(Used for reporting purposes.)*

HEIGHT: FT IN **OR** CM WEIGHT: LBS OR KG

Name of Medications/supplements you are taking for the treatment of Kidney Stones:	Date started	Date ended

Medical Information (Check ALL that apply to you and provide dates for events checked)

Have you ever been diagnosed with either of these two conditions below?

☐ Crohn's ___/___/___

☐ Ulcertative colitis ___/___/___
Date Diagnosed

Have you been placed on either diet for the treatment of Kidney stones?

☐ Low Sodium Diet ___/___/___

☐ Low Fat Diet ___/___/___
Date Started

Have you ever had any of the surgeries listed below? Check all that apply

☐ Colectomy ___/___/___

☐ Ileostomy ___/___/___

☐ Gastric bypass/ Weight loss surgery ___/___/___

☐ Small Bowel Resection ___/___/___
Date of Event

Insurance Information Form

All information must be filled out completely on both sides of the form and returned with your sample(s).

Patient Information (Please send a photocopy of your insurance card.)

LAST NAME: FIRST NAME: DATE OF BIRTH:

Primary Insurance Information

INSURANCE PLAN NAME: PHONE NUMBER: ( )

POLICY, SUBSCRIBER OR MEMBERSHIP NUMBER:

GROUP NUMBER OR PLAN CODE NUMBER:

INSURANCE COMPANY ADDRESS FOR CLAIM SUBMISSION:

CITY: STATE: ZIP CODE:

Complete this section only if you are covered by insurance under someone else's policy.

INSURED LAST NAME: FIRST NAME: MI:

INSURED DATE OF BIRTH:

YOUR RELATIONSHIP TO THE PRIMARY INSURED: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

Secondary Insurance Information (Complete this section only if you have additional insurance.)

INSURED LAST NAME: FIRST NAME: MI:

INSURED DATE OF BIRTH:

YOUR RELATIONSHIP TO THE SECONDARY INSURED: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

INSURANCE PLAN NAME: PHONE NUMBER: ( )

POLICY, SUBSCRIBER OR MEMBERSHIP NUMBER:

GROUP NUMBER OR PLAN CODE NUMBER:

INSURANCE COMPANY ADDRESS FOR CLAIM SUBMISSION:

CITY: STATE: ZIP CODE:

Insurance Billing and Privacy Information

I authorize Litholink to bill my insurance company for the laboratory services ordered by my physician. I have completed the insurance information form for that purpose. Litholink will bill you for your coinsurance and/or deductible. If payment is a hardship please advise. Call us with any questions about billing or insurance at 800 338 4333.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE:

PRINT NAME: DATE: