Long Beach Memorial Pathology Medical Group
2840 Long Beach Blvd. #430
Long Beach, CA 90806

Add on test confirmation:

Date of Request: ___________________ **Time:** ________________

Requested By (PRINT):_____________________________

This is to confirm the following tests to be ordered:

Case #	Patient Name	HR-HPV	GC/Chlamydia	HPV 16, 18/45	Trich	Other Test

Please return by fax to 562-989-5960

LBM PATHOLOGY LAB USE ONLY:

Order Received by: ____________ Date: ___________ Time: ______________