Date of Request ______________________ Visit Number: ________________________

Chart #: ____________________ Location ________________

Patient Name ________________________________

Date of Birth ____

Ordering Provider ________________________________

BASSETT HEALTHCARE NETWORK
1 Atwell Rd
Cooperstown, NY 13326
Phone: (607)547-3720
Fax: (607)547-3755

3/3/21

SPECIMEN COLLECTED BY:	TIME:	DATE:

Albany Medical Center Testing

☐ HBFS: Fetal Hemoglobin Stain

PLEASE FAX RESULTS TO: ____________________

AND

Call Results TO: ____________________________

Received By:____