



# LAB PRESCRIPTION

## SHIPPING ADDRESS:

**3755 WATERLILLY WAY MARIETTA, GA 30067**

**(770)980-9286**

Date ORDERED:

Doctor Name:

Address:

Phone Number:

Dr. License Number:

Dr. Signature:

Patient Name:

Sex:

Present Shade:

Shade Requested:

Date DUE:

### INSTRUCTIONS:

