

## **REQUISITION: Outpatient Practices – Appointment Card**

This form is for Stony Brook Medicine outpatient (ambulatory) practices only.

All information must be filled out to process order efficiently. Please do not write in shaded areas.

Please allow at least 2 weeks for processing.

REQUISITION NUMBER: (AUTOMATICALLY ASSIGNED AFTER PRINTING)

BILLING	Department/Office					
	Account #		Type of Account			
	Ordered By		Authorized Signature			Date
	Job#	PO #		Date to Printer		Due Out
CONTACT	Name				Phone	
(In case we have a question)	Email				Fax	
SUBMIT FORM TO	Interoffice Health Sciences Print Center, Health Sciences Tower, Level 1, (Internal Zip = 8013)  Email James.Manssino@stonybrookmedicine.edu				Questions? Call (631) 444-2642	
STYLE/TYPE OF CARD NEEDED  (Check appropriate box. All cards will be printed red and black. All others will be as specified.)	One practice, single location One practice, multiple locations Add QR code?* Yes No *If yes, you will need to supply your own QR code file. Instructions for how to do so are available on the SBM Marketing Communications Toolkit (scan QR code below).					
ORDER	ORDER Quantity (1 box = 500 cards)					
	Information for Appointment Cards SINGLE LOCATION: Practice Name Address Line 1 Address Line 2 City Phone Fax (optional) Website (if other than stonybrookmedicine.edu) MULTIPLE LOCATIONS: (up to 4 – please indicate if within an Advanced Specialty Care facility) Practice Name Location 1: Address, City Location 2: Address, City Location 3: Address, City Location 4: Address, City Phone Fax (optional) Website (if other than stonybrookmedicine.edu) Website (if other than stonybrookmedicine.edu)					
DELIVERY	Name			Building/Floor/Room	Depa	rtment/Office (if different from billing)
(Note: please keep a copy for your records.)	No. of Boxes	Received By				Date Received
These examples are for illustrative purposes only. Scan the QR code to view more examples on our website	Stony Brook Medicine  Practice Name  Address line 1  Address line 2 City  P 651.XXX.XXXX F 6531.XXX.XXXXX  stonybrookmedicine edu	You have an appointm  OM OT OW OTh  Date:  at		Stony Brook M  Practice Name    Location, City   Location, City   Location, City   Indian Advanced Specialty City		You have an appointment with  OM OT OW OTH OF OS  Date:atOam Opm
	Front	If unable to keep this appointment, kind		Front		If unable to keep this appointment, kindly give 24 hours' notice.  stonybrookmedicine.edu  P 631.XXX.XXXXX F 631.XXX.XXXXX