

<p><b>PATIENT INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</p> <p><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>ABN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>WORKERS COMP:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p><b>PRIMARY:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach)</p> <hr/> <p><b>DIAGNOSIS CODE (REQUIRED)</b> ICD-10 Codes 1. _____ 2. _____ 3. _____</p>	<p style="text-align: center;"><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING PHYSICIAN CONTACT</b></p> <p>Physician Name _____</p> <hr/> <p>Physician NPI# _____ Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <hr/> <p>Physician Signature _____</p> <p><input type="checkbox"/> Call results to phone number: ( _____ ) _____</p> <p><input type="checkbox"/> Fax report to: ( _____ ) _____</p> <hr/> <p><b>SPECIMEN INFORMATION</b></p> <p>Collection Date: ____/____/____ Time: _____</p> <p><b>Specimen Type</b> <input type="checkbox"/> Serum <input type="checkbox"/> Plasma</p> <p><input type="checkbox"/> Urine – volume _____ # hours _____</p> <p><input type="checkbox"/> Whole Blood <input type="checkbox"/> Other (specify) _____</p> <p><input type="checkbox"/> Fasting _____ hours <input type="checkbox"/> Non-fasting</p>			
<p><b>INDICATE TESTS REQUIRED</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top; padding: 5px;"> <p><b>CHEMISTRY PANELS</b></p> <p><input type="checkbox"/> Basic Metabolic Panel (PST) <i>BMP</i></p> <p><input type="checkbox"/> Comprehensive Metabolic Panel (PST) <i>CMP</i></p> <p><input type="checkbox"/> Hepatic Function Panel (PST) <i>HFP</i></p> <p><input type="checkbox"/> Lipid Panel (PST) <i>LIPB</i></p> <p><b>HEMATOLOGY PANELS</b></p> <p><input type="checkbox"/> Complete Blood Count (LAV) <i>CBC</i></p> <p><input type="checkbox"/> Complete Blood Count w/ Differential (LAV) <i>CBCDIF</i></p> <p><b>ALPHABETICAL TESTS</b></p> <p><input type="checkbox"/> Amylase (SST) <i>AMYL</i></p> <p><input type="checkbox"/> Anti-Nuclear Antibody by EIA (SST) <i>ANAS</i></p> <p><input type="checkbox"/> AST (PST) <i>AST</i></p> <p><input type="checkbox"/> Vitamin B12 (PST) <i>B12</i></p> <p><input type="checkbox"/> Creatine Kinase (PST) <i>CK</i></p> <p><input type="checkbox"/> C-Reactive Protein (SST) <i>CRP</i></p> <p><input type="checkbox"/> Ferritin (PST) <i>FERR</i></p> <p><input type="checkbox"/> Thyroxine Free (SST) <i>FT4</i></p> <p><input type="checkbox"/> Hemoglobin A1C (LAV) <i>HBA1C</i></p> </td> <td style="width:33%; 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