Cleveland Clinic Laboratories

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Cleveland, OH 44106
216.444.5755 or 800.628.6816

☐ Split Specimen

PHYSICIAN REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name ______ First ______ MI ______

Address ______ Birth Date ______ Sex ☐ M ☐ F

City ______ SS # ______

State ______ Zip ______ Home Phone ______

Hospital/Physician Office Patient ID # ______ Accession # ______

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name ______

Physician Signature ______

Physician NPI# ______

Physician Phone ______

Physician Email ______

☐ Call Results to phone number: (______) ______

☐ Fax report to: (______) ______

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.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: ______/______/______

ABN: ☐ Yes ☐ No **WORKERS COMP.:** ☐ Yes ☐ No DOI: ______

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

SECONDARY: ☐ No ☐ Yes (if Yes, please attach)

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. ______ 2. ______ 3. ______

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time: ______

Specimen Type: ☐ Serum ☐ Plasma

☐ Urine – volume ______ #hours ______

☐ Whole Blood Other (specify) ______

☐ Fasting ______ hours ☐ Non-fasting

INDICATE TESTS REQUESTED (* limited coverage tests – ABN may be needed)

ORGAN/DISEASE PANELS

- ☐ **ACUTE HEPATITIS PANEL*** *HACUTP*: *HBSAG, AHBCM, AHAVM, AHCV*
- ☐ **BASIC METABOLIC PANEL** *BMP*: *BUN, CA, CO2, CRET1, K1, NA*
- ☐ **COMPREHENSIVE METABOLIC PANEL** *CMP*: *TP, ALB, CA, TBIL, ALKP, AST, GLU, BUN, CRET1, NA, K1, CL, CO2, ALT*
- ☐ **LIPID PANEL*** *LIPB*: *CHOL, HDL, LDLDCT, TRIG*
- ☐ **HEPATIC FUNCTION PANEL*** *HFP*: *ALB, TBIL, CBIL, ALKP, AST, ALT, TP*
- ☐ **RENAL FUNCTION PANEL** *RFP*: *ALB, BUN, CA, PHOS, GLU, BUN, CRET1, NA, K1, CL, CO2*
- ☐ **OBSTETRIC SERIES (non-Medicare)**: *ABORH, TSCR, CBCDIF, HBSAG, RUBQNT, RPR*

GENERAL LABORATORY TESTS

- ☐ Albumin *ALB*
- ☐ ALT (SGPT) *ALT*
- ☐ Amylase *AMYL*
- ☐ ANA (titered if positive) *ANA1*
- ☐ AST (SGOT) *AST*
- ☐ BNP, NT Pro* *NTBNP*
- ☐ BUN *BUN*
- ☐ CA 125 * *CA125*
- ☐ CA15-3 * *CA153*
- ☐ CA19-9 * *CA199*
- ☐ Ionized Calcium *ICA*
- ☐ CBC * *CBC*
- ☐ CBC/Diff * *CBCDIF*
- ☐ CEA * *CEA*
- ☐ CRP *CRP*
- ☐ High Sensitivity CRP * *HSCRP*
- ☐ Digoxin * *DIG*
- ☐ EBV Panel *EBVPNL*
- ☐ Ferritin *FERR*
- ☐ Gamma GT * *GGT*
- ☐ Glucose Fasting *GLF*
- ☐ Glucose Random * *GLU*
- ☐ HCG Quantitative Blood * *HCGQT*
- ☐ HCG Qualitative Urine * *UHCG*
- ☐ Hemoglobin A1C * *HBA1C*
- ☐ Hepatitis A Antibody, Total *AHAVT*
- ☐ Hepatitis B Surface Antigen *HBSAG*
- ☐ Hepatitis C Antibody *AHCV*
- ☐ HIV 1,2 Combo (Antigen/Antibody)* *HIV12C*
- ☐ Iron and TIBC * *IRON*
- ☐ Lead *LEAD2* Heavy Metal Demographic required *HMDEMO*
- ☐ Lipase *LIPA*
- ☐ Lupus Anticoag Diagnostic Interpretive Panel *LUPUSP*
- ☐ Magnesium *MG1*
- ☐ Microalbumin Urine *UALBR*
- ☐ Myoglobin *MYOGLB*
- ☐ Pertussis IgG, IgM, IgA *BPPABS*
- ☐ Prealbumin *PREALB*
- ☐ PSA, Diagnostic *PSA*
- ☐ PSA, Free and Total *PSATF*
- ☐ PSA Screen *PSAS1*
- ☐ PT*/INR *PT*
- ☐ PTT * *PTT*
- ☐ RPR (titered if positive) *RPR*
- ☐ Syphilis IgG with Confirmation *SYPHGX*
- ☐ Sedimentation Rate *WSR*
- ☐ T3 Total * *T3*
- ☐ T3 Free * *FREET3*
- ☐ T4 Free * *FT4*
- ☐ T4 * *T4*
- ☐ Total Bilirubin *TBIL*
- ☐ TSH * *TSH*
- ☐ Uric Acid *URIC*
- ☐ Urinalysis *UA*
- ☐ Urinalysis with microscopic *UAWMIC*
- ☐ Urine Drug Screen * *UTOX2*
- ☐ Vitamin B12 * *B12*
- ☐ Vitamin D * *VITD*

MICROBIOLOGY

- ☐ Specimen Source/Method (specify: ______)
- ☐ Chlamydia Amplified DNA Probe (specify: ______)
- ☐ GC Amplified DNA Probe (specify: ______)
- ☐ *Clostridium Difficile* Toxin by PCR *CDPCR*
- ☐ Fungus Culture (hair, skin, nails)
- ☐ Group B Strep Culture (anal/genital)
- ☐ HSV, PCR *HSPCR*
- ☐ Blood Culture *BLCUL*
- ☐ Staphylococcus aureus by PCR *SAPCR*
- ☐ Group A Strep by PCR (throat) *GASPCR*
- ☐ *Trichomonas Vaginalis* Amplification *TRVAMP*
- ☐ Urine Culture * (specify method of collection above) *URCUL*
- ☐ Wound Culture/Superficial (specify source above)
- ☐ Wound Culture/Deep-Surgical (specify source above)

BLOOD BANK

- ☐ ABO Rh Typing *ABORH*
- ☐ Type and Screen *TSCR*

ADDITIONAL TEST/COMMENTS

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