

HEAVY METAL REQUISITION DEMOGRAPHICS FORM

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<p>PATIENT INFORMATION (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 _____ County _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <p>THE STATE OF OHIO REQUIRES THE FOLLOWING INFORMATION WHEN ORDERING LEAD, CADMIUM, MERCURY OR ARSENIC</p> <p>ETHNICITY: <input type="checkbox"/> Unknown (:Z) <input type="checkbox"/> Hispanic (:H) <input type="checkbox"/> Non-Hispanic (:N) <input type="checkbox"/> Other (:O)</p> <p>RACE: <input type="checkbox"/> Unknown (:Z) <input type="checkbox"/> White (:W) <input type="checkbox"/> Black (:B) <input type="checkbox"/> Asian (:A) <input type="checkbox"/> Native American (:N)</p> <hr/> <p>Name of guardian/parent (if patient is under 16 years of age) _____</p> <p>PLEASE COMPLETE THE FOLLOWING SECTION WHEN A COPY OF INSURANCE CARD (FRONT AND BACK) IS NOT PROVIDED.</p> <p>PRIMARY: <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>SECONDARY: <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>WORKER'S COMPENSATION</p> <hr/> <p>Claim# _____ Date of Injury _____</p> <p>BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)</p> <p>BILL TO: <input type="checkbox"/> Client <input type="checkbox"/> Patient <input type="checkbox"/> Medicare <input type="checkbox"/> Other Insurance</p> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes</p> <p>1. _____ 2. _____ 3. _____</p> <p>MEDICAL NECESSITY NOTICE</p> <p>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>INDICATE TESTS REQUESTED</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Arsenic, Blood <i>ASB</i></td> <td><input type="checkbox"/> Cadmium, Blood <i>CADM</i></td> <td><input type="checkbox"/> Heavy Metals with Cadmium, Ur <i>UTXM4</i></td> <td><input type="checkbox"/> Mercury, Blood <i>MERC2</i></td> </tr> <tr> <td><input type="checkbox"/> Arsenic, Fractionated Urine <i>UASFR</i></td> <td><input type="checkbox"/> Cadmium Exposure Panel, OSHA <i>CADEXR</i></td> <td><input type="checkbox"/> Heavy Metals with Cadmium, Whole Blood <i>HEVMT4</i></td> <td><input type="checkbox"/> Mercury, Urine 24 Hour <i>UMERC3</i></td> </tr> <tr> <td><input type="checkbox"/> Arsenic, Hair <i>ARSHR</i></td> <td><input type="checkbox"/> Cadmium, Urine <i>URCAD</i></td> <td><input type="checkbox"/> Lead, Blood <i>LEAD2</i></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Arsenic, Nails <i>ARSNL</i></td> <td><input type="checkbox"/> Heavy Metals Screen, Whole Blood <i>HEVMET</i></td> <td><input type="checkbox"/> Lead, Urine 24 Hour <i>ULEADQ</i></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Arsenic, Urine 24 Hr <i>UARSND</i></td> <td><input type="checkbox"/> Heavy Metals, Urine <i>UTXM3</i></td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> Arsenic, Blood <i>ASB</i>	<input type="checkbox"/> Cadmium, Blood <i>CADM</i>	<input type="checkbox"/> Heavy Metals with Cadmium, Ur <i>UTXM4</i>	<input type="checkbox"/> Mercury, Blood <i>MERC2</i>	<input type="checkbox"/> Arsenic, Fractionated Urine <i>UASFR</i>	<input type="checkbox"/> Cadmium Exposure Panel, OSHA <i>CADEXR</i>	<input type="checkbox"/> Heavy Metals with Cadmium, Whole Blood <i>HEVMT4</i>	<input type="checkbox"/> Mercury, Urine 24 Hour <i>UMERC3</i>	<input type="checkbox"/> Arsenic, Hair <i>ARSHR</i>	<input type="checkbox"/> Cadmium, Urine <i>URCAD</i>	<input type="checkbox"/> Lead, Blood <i>LEAD2</i>		<input type="checkbox"/> Arsenic, Nails <i>ARSNL</i>	<input type="checkbox"/> Heavy Metals Screen, Whole Blood <i>HEVMET</i>	<input type="checkbox"/> Lead, Urine 24 Hour <i>ULEADQ</i>		<input type="checkbox"/> Arsenic, Urine 24 Hr <i>UARSND</i>	<input type="checkbox"/> Heavy Metals, Urine <i>UTXM3</i>			<p>CLIENT INFORMATION</p> <hr/> <p>SAMPLE INFORMATION (REQUIRED)</p> <p>Collection Date: ____/____/____ Time: _____</p> <p>Collected by: _____</p> <p>Specimen Type:</p> <p><input type="checkbox"/> Venous Blood (:V) or <input type="checkbox"/> Capillary Blood (:C)</p> <p><input type="checkbox"/> Random Urine or <input type="checkbox"/> 24 hours/volume _____ ml</p> <p>PHYSICIAN INFORMATION (REQUIRED)</p> <hr/> <p>Physician Signature _____</p> <hr/> <p>Date / Time _____</p> <hr/> <p>Physician Name (please print) _____</p> <hr/> <p>Address _____</p> <hr/> <p>City, State, Zip _____</p> <hr/> <p>Phone _____ UPIN _____</p> <p><input type="checkbox"/> Send additional report</p> <p>Physician: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p><input type="checkbox"/> Call Results to phone number: (_____) _____</p> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <p>EMPLOYER INFORMATION (REQUIRED)</p> <hr/> <p>Patient's Employer (or ;NA) _____</p> <hr/> <p>Address (or ;NA) _____</p> <hr/> <p>City (or ;NA), State (or ;NA), Zip (or ;NA) _____</p>
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Ohio Administrative Codes 3701-30-05 and 3701-32-14 state that any physician or healthcare provider requesting analysis for lead, cadmium, arsenic or mercury shall complete each request with the above information.

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