Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

EXTENDED CARE 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 #

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. _____

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

Physician Signature

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

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*:** HAAB-IGM, HBcAB-IGM, HBsAG, HCVAB
- ☐ **BASIC METABOLIC PANEL:** BUN, Ca, Cl, CO2, Creat., Gluc, K, Na
- ☐ **COMPLETE METABOLIC PANEL:** Alb, Aphos, ALT, AST, TBili, BUN, Ca, Cl, CO2, Creat., Gluc, K, Na, TProt
- ☐ **ELECTROLYTE PANEL:** Cl, CO2, K, Na
- ☐ **LIPID PANEL*:** Chol, HDL, LDL(Calc), Trig, VLDL(Calc)
- ☐ **HEPATIC FUNCTION PANEL*:** Alb, DBili, TBill, APhos, ALT, AST, TProt
- ☐ **OBSTETRIC PANEL (non-Medicare):** ABO, Rh, ABSCR, CBC/diff, HBsAg, Rubella
- ☐ **RENAL FUNCTION PANEL:** Alb, BUN, Ca, Cl, CO2, Creat, Gluc, K, Phos, Na

GENERAL LABORATORY TESTS

- ☐ 24 Hour Urine Calcium
- ☐ 24 Hour Urine Creatinine
- ☐ 24 Hour Urine Creatinine Clearance Ht:_____ Wt:_____
- ☐ 24 Urine Protein
- ☐ 24 Urine Urea Nitrogen
- ☐ Albumin
- ☐ ALT (SGPT)
- ☐ Amylase
- ☐ ANA (titered if positive)
- ☐ AST (SGOT)
- ☐ BNP, NT Pro *
- ☐ BUN
- ☐ CA 125 *
- ☐ CA15-3 *
- ☐ CA19-9 *
- ☐ Calcium
- ☐ CBC *
- ☐ CBC/Diff *
- ☐ CEA *
- ☐ Cholesterol
- ☐ Creatinine
- ☐ CRP
- ☐ CRP, Cardio * (high sensitivity CRP)
- ☐ Digoxin *
- ☐ Dilantin (Phenytoin) Total
- ☐ Ferritin
- ☐ Gamma GT *
- ☐ Glucose Blood *
- ☐ Glucose ____ hr Postprandial *
- ☐ Glucose Tolerance ___ hr ____ gms
- ☐ HCG, Quantitative *
- ☐ HDL *
- ☐ Hematocrit *
- ☐ Hemoglobin *
- ☐ Hemoglobin A1C *
- ☐ Hepatitis A Antibody Total (HAAB)
- ☐ Hepatitis B Surface Antibody (HBsAB) (confirmation if positive) (HBsAG)
- ☐ Hepatitis C Antibody (HCVAB)
- ☐ HIV-1 and 2, Single Assay *
- ☐ Iron *
- ☐ Lipase
- ☐ Lithium
- ☐ Magnesium
- ☐ Microalbumin Urine
- ☐ Myoglobin
- ☐ Phosphorus
- ☐ Platelet Count
- ☐ Potassium
- ☐ Prealbumin
- ☐ Pregnancy Test Serum *
- ☐ Pregnancy Test Urine *
- ☐ Protein, Total
- ☐ PSA Free
- ☐ PSA Screen
- ☐ PSA Total
- ☐ PT*/INR
- ☐ PTT *
- ☐ Reticulocyte Count
- ☐ RPR (titered if positive)
- ☐ Sedimentation Rate
- ☐ Stool Occult Blood Screen *
- ☐ Stool Occult Blood Single Specimen *
- ☐ T Uptake *
- ☐ T3 Total *
- ☐ T4 Free *
- ☐ T4 *
- ☐ TIBC *
- ☐ Triglycerides
- ☐ Troponin
- ☐ TSH*/TSH 3rd Gen *
- ☐ Uric Acid
- ☐ Urinalysis with microscopic
- ☐ Urinalysis without microscopic
- ☐ Urine Drug Screen *
- ☐ Vancomycin _____ random
- ☐ Vitamin B12 *
- ☐ Vitamin D *
- ☐ WBC *

MICROBIOLOGY

- ☐ Specimen Source/Method (specify: _____)
- ☐ Blood Culture
- ☐ Chlamydia Amplified DNA Probe (source: _____)
- ☐ GC Amplified DNA Probe (source: _____)
- ☐ Clostridium Difficile Assay
- ☐ Fungus Culture (hair, skin, nails)
- ☐ Group B Strep Culture (anal/genital)
- ☐ Human Papilloma Virus * (HPV)
- ☐ O&P Full Microscopic Examination
- ☐ O&P Giardia Antigen Detection by EIA
- ☐ Stool Culture (salmonella/shigella/campylobacter)
- ☐ Throat - Group A Strep Culture
- ☐ Throat - Rapid Group A Strep (with Group A confirmation)
- ☐ Urine Culture * (specify method of collection above)
- ☐ Wound Culture/Superficial (specify source above)
- ☐ Wound Culture/Deep-Surgical (specify source above)

BLOOD BANK

- ☐ ABO
- ☐ Rh
- ☐ Antibody Screen

ADDITIONAL TEST/COMMENTS

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