

<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><small>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.</small></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>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> <hr/> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please attach) <b>ABN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</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# _____</p> <hr/> <p>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>Specimen Type: <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 REQUESTED (* limited coverage tests – ABN may be needed)</b></p> <p><b>ORGAN/DISEASE PANELS</b> <i>*panel components may be ordered individually</i></p> <p><input type="checkbox"/> <b>ACUTE HEPATITIS PANEL* HACUTP:</b> AHAVM, AHBCM, AHCV, HBSAG</p> <p><input type="checkbox"/> <b>BASIC METABOLIC PANEL BMP:</b> BUN, CA, CL, CO2, CRET1, GLU, K1, NA</p> <p><input type="checkbox"/> <b>COMPLETE METABOLIC PANEL CMP:</b> ALB, BUN, CA, CO2, CL, CRET1, GLU, K1, NA, TBIL, TP, ALT, ALKP, AST</p> <p><input type="checkbox"/> <b>ELECTROLYTE PANEL LYTE:</b> CL, CO2, K1, NA</p> <p><input type="checkbox"/> <b>LIPID PANEL* LIPB:</b> CHOL, HDL, LDLCT, TRIG</p> <p><input type="checkbox"/> <b>HEPATIC FUNCTION PANEL* HFP:</b> ALB, ALKP, ALT, AST, CBIL, TBIL, TP</p> <p><input type="checkbox"/> <b>RENAL FUNCTION PANEL RFP:</b> ALB, BUN, CA, CL, CO2, CRET1, GLU, K1, NA, PHOS</p> <p><input type="checkbox"/> <b>OBSTETRIC SERIES (non-Medicare):</b> ABORH, TSCR, CBCDF, HBSAG, RUBQNT, RPR</p> <p><b>GENERAL LABORATORY TESTS</b></p> <p><input type="checkbox"/> 24 Hour Urine Calcium <b>UCALCD</b></p> <p><input type="checkbox"/> 24 Hour Urine Creatinine <b>UCRD</b></p> <p><input type="checkbox"/> 24 Hour Urine Creatinine Clearance <b>UXCC</b> Ht: _____ Wt: _____</p> <p><input type="checkbox"/> 24 Urine Protein <b>UTP24</b></p> <p><input type="checkbox"/> 24 Urine Urea Nitrogen <b>UUND</b></p> <p><input type="checkbox"/> Albumin <b>ALB</b></p> <p><input type="checkbox"/> ALT (SGPT) <b>ALT</b></p> <p><input type="checkbox"/> Amylase <b>AMYL</b></p> <p><input type="checkbox"/> ANA (titered if positive) <b>ANA1</b></p> <p><input type="checkbox"/> AST (SGOT) <b>AST</b></p> <p><input type="checkbox"/> BNP, NT Pro* <b>NTBNP</b></p> <p><input type="checkbox"/> BUN <b>BUN</b></p> <p><input type="checkbox"/> CA 125 * <b>CA125</b></p> <p><input type="checkbox"/> CA15-3 * <b>CA153</b></p> <p><input type="checkbox"/> CA19-9 * <b>CA199</b></p> <p><input type="checkbox"/> Calcium <b>CA</b></p> <p><input type="checkbox"/> CBC * <b>CBC</b></p> <p><input type="checkbox"/> CBC/Diff * <b>CBCDF</b></p> <p><input type="checkbox"/> CEA * <b>CEA</b></p> <p><input type="checkbox"/> Cholesterol <b>CHOL</b></p> <p><input type="checkbox"/> Creatinine <b>CRET1</b></p> <p><input type="checkbox"/> CRP <b>CRP</b></p> <p><input type="checkbox"/> Digoxin * <b>DIG</b></p> <p><input type="checkbox"/> Dilantin (Phenytoin) Total <b>PHT</b></p> <p><input type="checkbox"/> Ferritin <b>FERR</b></p> <p><input type="checkbox"/> Gamma GT * <b>GGT</b></p> <p><input type="checkbox"/> Glucose Blood * <b>GLU</b></p> <p><input type="checkbox"/> Glucose _____ hr Postprandial *</p> <p><input type="checkbox"/> Glucose Tolerance _____ hr _____ gms</p> <p><input type="checkbox"/> HCG Quantitative Blood * <b>HCGQT</b></p> <p><input type="checkbox"/> HDL * <b>HDL1</b></p> <p><input type="checkbox"/> Hematocrit * <b>HCT</b></p> <p><input type="checkbox"/> Hemoglobin * <b>HGB</b></p> <p><input type="checkbox"/> Hemoglobin A1C * <b>HBA1C</b></p> <p><input type="checkbox"/> Hepatitis A Antibody, Total <b>AHAVT</b></p> <p><input type="checkbox"/> Hepatitis B Surface Antigen (confirmation if positive) <b>HBSAG</b></p> <p><input type="checkbox"/> Hepatitis C Antibody <b>AHCV</b></p> <p><input type="checkbox"/> High Sensitivity CRP * <b>HSCRP</b></p> <p><input type="checkbox"/> HIV 1,2 Combo (Antigen/Antibody)* <b>HIV12C</b></p> <p><input type="checkbox"/> Iron * <b>IRN1</b></p> <p><input type="checkbox"/> Lipase <b>LPA</b></p> <p><input type="checkbox"/> Lithium <b>LI</b></p> <p><input type="checkbox"/> Magnesium <b>MG1</b></p> <p><input type="checkbox"/> Microalbumin Urine <b>UALBR</b></p> <p><input type="checkbox"/> Myoglobin <b>MYOGLB</b></p> <p><input type="checkbox"/> Phosphorus <b>PHOS</b></p> <p><input type="checkbox"/> Platelet Count <b>PLTCT</b></p> <p><input type="checkbox"/> Potassium <b>K1</b></p> <p><input type="checkbox"/> Prealbumin <b>PREALB</b></p> <p><input type="checkbox"/> Protein, Total <b>TP</b></p> <p><input type="checkbox"/> PSA, Free <b>PSATF</b></p> <p><input type="checkbox"/> PSA Screen <b>PSASI</b></p> <p><input type="checkbox"/> PT*/INR <b>PT</b></p> <p><input type="checkbox"/> PTT * <b>PTT</b></p> <p><input type="checkbox"/> Reticulocyte Count <b>RETIC</b></p> <p><input type="checkbox"/> RPR (titered if positive) <b>RPR</b></p> <p><input type="checkbox"/> Sedimentation Rate <b>WSR</b></p> <p><input type="checkbox"/> Stool Occult Blood Screen *</p> <p><input type="checkbox"/> Stool Occult Blood Single Specimen *</p> <p><input type="checkbox"/> T3 Uptake * <b>T3U</b></p> <p><input type="checkbox"/> T3 Total * <b>T3</b></p> <p><input type="checkbox"/> T4 Free * <b>FT4</b></p> <p><input type="checkbox"/> T4 * <b>T4</b></p> <p><input type="checkbox"/> TIBC * <b>IRON</b></p> <p><input type="checkbox"/> Triglycerides <b>TRIG</b></p> <p><input type="checkbox"/> Troponin <b>TNT</b></p> <p><input type="checkbox"/> TSH * <b>TSH</b></p> <p><input type="checkbox"/> Uric Acid <b>URIC</b></p> <p><input type="checkbox"/> Urinalysis with microscopic <b>UAWMIC</b></p> <p><input type="checkbox"/> Urinalysis <b>UA</b></p> <p><input type="checkbox"/> Urine Drug Screen * <b>UTOX2</b></p> <p><input type="checkbox"/> Vancomycin <b>VANCRA</b></p> <p><input type="checkbox"/> Vitamin B12 * <b>B12</b></p> <p><input type="checkbox"/> Vitamin D * <b>VITD</b></p> <p><input type="checkbox"/> WBC * <b>WBC</b></p> <p><input type="checkbox"/> Group B Strep Culture (anal/genital) <b>GBPCR</b></p> <p><input type="checkbox"/> HPV DNA PCR (Thinprep, no PAP incl.) <b>HPVHRT</b></p> <p><input type="checkbox"/> HPV DNA PCR (Surepath, no PAP incl.) <b>HPVHRS</b></p> <p><input type="checkbox"/> Ova &amp; Parasite exam <b>OVAP</b></p> <p><input type="checkbox"/> Cryptosporidium &amp; Giardia EIA <b>OVAPSC</b></p> <p><input type="checkbox"/> Aeromonas/Plesiomonas Culture (stool – Salmonella, Shigella, Campylobacter) <b>AERPLE</b></p> <p><input type="checkbox"/> Throat – Group A Strep by PCR <b>GASPCR</b></p> <p><input type="checkbox"/> Urine Culture * (specify method of collection above) <b>URCUL</b></p> <p><input type="checkbox"/> Wound Culture/Superficial (specify source above)</p> <p><input type="checkbox"/> Wound Culture/Deep-Surgical (specify source above)</p> <p><b>BLOOD BANK</b></p> <p><input type="checkbox"/> ABO Rh Typing <b>ABORH</b></p> <p><input type="checkbox"/> Type and Screen <b>TSCR</b></p> <p><b>ADDITIONAL TEST/COMMENTS</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	