Cleveland Clinic Laboratories

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

HOSPITAL TEST 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

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: _____/_____/_____

PRIMARY: ☐ Medicare ☐ Medicaid (OH only) ☐ 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) **ABN:** ☐ No ☐ Yes

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

CLINICAL HISTORY _____

ORDERING PHYSICIAN CONTACT

Physician Name: _____

Physician NPI#: _____

Physician Phone: _____

Physician Email: _____

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time: _____

Collected By: _____

Specimen Type ☐ Serum ☐ Plasma

☐ Urine – volume _____ # hours _____

☐ Whole Blood ☐ Other (specify) _____

☐ Fasting _____ hours ☐ Non-fasting

☐ Send additional report

Physician: _____

Address: _____

City, State, Zip: _____

INDICATE TESTS REQUESTED

- ☐ 17 Hydroxyprogesterone *HPROG*
- ☐ ACE, CSF *CACE*
- ☐ AFB Culture and Stain *AFC*
- ☐ AFB Organism ID *OIDAFB*
- ☐ AFB Susceptibility *AFBSUS*
- ☐ Albumin/Creatinine Ratio, urine, random (U) *UACR*
- ☐ Aldosterone (P) (F) *ALDO*
- ☐ ANA *ANAS*
- ☐ APTT (P) (F) *PTT*
- ☐ C-Reactive Protein (P) *CRP*
- ☐ Cardiolipin Antibodies *CARDIO*
- ☐ Catecholamine fraction, plasma (P) (F) *PLCAT*
- ☐ Coag Core Panel (P) (F) *CORPNL*
- ☐ Cystatin C *CYSTC*
- ☐ Dilute RVVT (P) (F) *DRVVT*
- ☐ EBV Antibody Panel *EBVPNL: EBVG, EBVM, EBVNA*
- ☐ EBV IgG Antibody *EBVG*
- ☐ EBV IgM Antibody *EBVM*
- ☐ EBV NA Antibody *EBVNA*
- ☐ Endomysial IgA Antibody *ENDOMY*
- ☐ Estrogens, fractionated * *ESTGEN*
- ☐ Fecal Fat, Qualitative *FFATQL*
- ☐ Fibrinogen (P) (F) *FIBCT*
- ☐ Flow Cytometry Leukemia/Lymphoma *RLLLIP*
- ☐ Free Kappa/Lambda Light Chains *KLFRS*
- ☐ Yeast Susceptibility Testing *FUNSUS*
- ☐ GC/Chlamydia Amplification *GCCT*
- ☐ Glomerular Basement Membrane IgG Antibody *GBMBG*
- ☐ Glutamic Acid Decarb Antibody (F) *GADCAB*
- ☐ Hemochromatosis (WB) (L) *HEMDNA*
- ☐ Hemoglobin A1c (WB) (L) *HBA1C*
- ☐ Heparin Anti Xa (P) (F) *HEPASY*
- ☐ Hepatitis B DNA, ultra quant (F) *HBVDNU*
- ☐ Hepatitis B Surface Antibody, Qualitative *AHBSAG*
- ☐ Hepatitis B Surface Antigen *HBSAG*
- ☐ Hepatitis Be Antibody *AHBE*
- ☐ Hepatitis Be Antigen *HBEAG*
- ☐ Hepatitis C Antibody (F) *AHCV1B*
- ☐ Histoplasma Antigen, urine (U) *UHISTO*
- ☐ HIV 1 and 2 Antibody *HIV12C*
- ☐ Hypercoagulation Diagnostic Panel * *HYPER*
- ☐ IgE *IGE*
- ☐ Iron and TIBC (P) * *IRON*
- ☐ Lamotrigine *LMTR*
- ☐ LPT to Beryllium (WB) *BLDBE*
- ☐ Lysozyme (P) (F) *LYSO2*
- ☐ Measles IgG Antibody *MEASLG*
- ☐ Methotrexate (P) *MTX*
- ☐ Methylmalonic Acid Blood *MMA*
- ☐ Organism ID Aerobe *OIDAER*
- ☐ Organism MIC, Bacterial *OMIC*
- ☐ Anti-Platelet Factor 4 (P) (F) *PLATF4*
- ☐ Platelet Neutralization (P) (F) *PLTNEU*
- ☐ Primadone (P) *PRIM*
- ☐ Prothrombin Gene Mutation (WB) (L) *PTGEN*
- ☐ Prothrombin Time (P) (F) *PT*
- ☐ PTH Related Peptide (P) (F) * *PTHPEP*
- ☐ PTH, Intact (F) *PTHI*
- ☐ Rheumatoid Factor (P) *RF*
- ☐ RPR *RPR*
- ☐ T3 *T3*
- ☐ Thrombin Time (P) (F) *TT*
- ☐ Thyroglobulin Antibody *TGAB*
- ☐ Varicella Zoster IgG Antibody *VZVG2*
- ☐ VDRL, CSF *VDRLCF*
- ☐ Vitamin D 25 Hydroxy *VITD*

ADDITIONAL TESTS

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

*LEGEND: Test requires serum unless noted. (F) Frozen (L) Lavender (P) Plasma (U) Urine (WB) Whole Blood *Requires special handling, see test directory*

*CPT codes available online at clevelandcliniclabs.com © 2025 Cleveland Clinic Laboratories 10/2025

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