

<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 _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p>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.</p> <p>INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p>PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p>WORKERS COMP: <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p>PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid (OH only) <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>SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) ABN: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p>	<p>CLIENT INFORMATION</p> <hr/> <p>ORDERING PHYSICIAN CONTACT</p> <p>Physician Name _____</p> <p>Physician Signature _____</p> <p>Physician NPI# _____</p> <p>Physician Phone _____</p> <p>Physician Email _____</p> <p><input type="checkbox"/> Call critical results to phone number: (_____) _____</p> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <hr/> <p>SPECIMEN INFORMATION</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 Other (specify) _____</p> <p><input type="checkbox"/> Fasting _____ hours <input type="checkbox"/> Non-fasting</p>
<p>INDICATE TESTS REQUESTED</p> <p>ORGAN/DISEASE PANELS <i>*panel components may be ordered individually</i></p> <p><input type="checkbox"/> ACUTE HEPATITIS PANEL* HACUTP: <i>AHAVM, AHBCM, AHCY1B, HBSAG</i></p> <p><input type="checkbox"/> BASIC METABOLIC PANEL BMP: <i>BUN, CA, CL, CO2, CRETI, GLU, K1, NA</i></p> <p><input type="checkbox"/> COMPREHENSIVE METABOLIC PANEL CMP: <i>ALB, BUN, CA, CO2, CL, CRETI, GLU, K1, NA, TBIL, TP, ALT, ALKP, AST</i></p> <p><input type="checkbox"/> LIPID PANEL* LIPB: <i>CHOL, HDL, LDLCT, TRIG</i></p> <p><input type="checkbox"/> HEPATIC FUNCTION PANEL* HFP: <i>ALB, ALKP, ALT, AST, CBIL, TBIL, TP</i></p> <p><input type="checkbox"/> RENAL FUNCTION PANEL RFP: <i>ALB, BUN, CA, CL, CO2, CRETI, GLU, K1, NA, PHOS</i></p> <p><input type="checkbox"/> OBSTETRIC SERIES (non-Medicare): <i>ABORH, TSCR, CBCDIF, HBSAG, RUBIGG, RPR</i></p> <p>GENERAL LABORATORY TESTS</p> <p><input type="checkbox"/> Albumin <i>ALB</i></p> <p><input type="checkbox"/> Albumin/Creatinine Ratio, Urine <i>UACR</i></p> <p><input type="checkbox"/> ALT (SGPT) <i>ALT</i></p> <p><input type="checkbox"/> Amylase <i>AMYL</i></p> <p><input type="checkbox"/> ANA (titered if positive) <i>ANA1</i></p> <p><input type="checkbox"/> AST (SGOT) <i>AST</i></p> <p><input type="checkbox"/> BNP, NT Pro* <i>NTBNP</i></p> <p><input type="checkbox"/> BUN <i>BUN</i></p> <p><input type="checkbox"/> CA 125 * <i>CA125</i></p> <p><input type="checkbox"/> CA15-3 * <i>CA153</i></p> <p><input type="checkbox"/> CA19-9 * <i>CA199</i></p> <p><input type="checkbox"/> Ionized Calcium <i>ICA</i></p> <p><input type="checkbox"/> CBC * <i>CBC</i></p> <p><input type="checkbox"/> CBC/Diff * <i>CBCDIF</i></p> <p><input type="checkbox"/> CEA * <i>CEA</i></p> <p><input type="checkbox"/> CRP <i>CRP</i></p> <p><input type="checkbox"/> High Sensitivity CRP * <i>HSCRCP</i></p> <p><input type="checkbox"/> Digoxin * <i>DIG</i></p> <p><input type="checkbox"/> EBV Antibody Panel <i>EBVPNL</i></p> <p><input type="checkbox"/> Ferritin <i>FERR</i></p> <p><input type="checkbox"/> Gamma GT * <i>GGT</i></p> <p><input type="checkbox"/> Glucose Fasting <i>GLF</i></p> <p><input type="checkbox"/> Glucose * <i>GLU</i></p> <p><input type="checkbox"/> HCG Quantitative Blood * <i>HCGQT</i></p> <p><input type="checkbox"/> HCG Qualitative Urine * <i>UHCG</i></p> <p><input type="checkbox"/> Hemoglobin A1C * <i>HBA1C</i></p> <p><input type="checkbox"/> Hepatitis A Antibody, IgG <i>AHAVG</i></p> <p><input type="checkbox"/> Hepatitis A Antibody, IgM <i>AHAVM</i></p> <p><input type="checkbox"/> Hepatitis B Surface Antigen <i>HBSAG</i></p> <p><input type="checkbox"/> Hepatitis C Antibody <i>AHCY1B</i></p> <p><input type="checkbox"/> HIV Screen * <i>HIV12C</i></p> <p><input type="checkbox"/> Iron and TIBC * <i>IRON</i></p> <p><input type="checkbox"/> Lead <i>LEAD2</i> Heavy Metal Demographic required</p> <p><input type="checkbox"/> Lipase <i>LIPA</i></p> <p><input type="checkbox"/> Lupus Anticoag Diagnostic Interpretive Panel <i>LUPUSP</i></p> <p><input type="checkbox"/> Magnesium <i>MGI</i></p> <p><input type="checkbox"/> Myoglobin <i>MYOGLB</i></p> <p><input type="checkbox"/> Prealbumin <i>PREALB</i></p> <p><input type="checkbox"/> PSA, Diagnostic <i>PSA</i></p> <p><input type="checkbox"/> PSA, Free and Total <i>PSATF</i></p> <p><input type="checkbox"/> PSA Screening <i>PSASI</i></p> <p><input type="checkbox"/> PT*/INR <i>PT</i></p> <p><input type="checkbox"/> Activated Partial Thromboplastin Time * <i>PTT</i></p> <p><input type="checkbox"/> RPR (titered if positive) <i>RPR</i></p> <p><input type="checkbox"/> Syphilis Treponemal with reflex <i>SYPHTX</i></p> <p><input type="checkbox"/> Sedimentation Rate, Westergren <i>WSR</i></p> <p><input type="checkbox"/> T3 Total * <i>T3</i></p> <p><input type="checkbox"/> T3 Free * <i>FREET3</i></p> <p><input type="checkbox"/> T4 Free * <i>FT4</i></p> <p><input type="checkbox"/> T4 * <i>T4</i></p> <p><input type="checkbox"/> Total Bilirubin <i>TBIL</i></p> <p><input type="checkbox"/> TSH * <i>TSH</i></p> <p><input type="checkbox"/> Uric Acid <i>URIC</i></p> <p><input type="checkbox"/> Urinalysis Only <i>UA</i></p> <p><input type="checkbox"/> Urinalysis with microscopic <i>UAWMIC</i></p> <p><input type="checkbox"/> Toxicology Screen, Urine * <i>UTOX2</i></p> <p><input type="checkbox"/> Vitamin B12 * <i>B12</i></p> <p><input type="checkbox"/> Vitamin D 25 Hydroxy * <i>VITD</i></p> <p>MICROBIOLOGY</p> <p><input type="checkbox"/> Specimen Source/Method (specify: _____)</p> <p><input type="checkbox"/> Chlamydia Amplified DNA Probe (specify: _____)</p> <p><input type="checkbox"/> GC Amplified DNA Probe (specify: _____)</p> <p><input type="checkbox"/> <i>Trichomonas Vaginalis</i> Amplification <i>TRVAMP</i> (specify: _____)</p> <p><input type="checkbox"/> <i>Bordetella Pertussis</i> DNA <i>BORAMP</i></p> <p><input type="checkbox"/> <i>Clostridium Difficile</i> Toxin by PCR <i>CDPCR</i></p> <p><input type="checkbox"/> Fungus Culture (hair, skin, nails)</p> <p><input type="checkbox"/> Group B Strep Culture (anal/genital)</p> <p><input type="checkbox"/> HSV 1&2, Qualitative PCR, CSF <i>HSPCRC</i></p> <p><input type="checkbox"/> Staphylococcus aureus & MRSA Screen, PCR <i>SAPCR</i></p> <p><input type="checkbox"/> Group A Strep by PCR (throat) <i>GASPCR</i></p> <p><input type="checkbox"/> Urine Culture * (specify method of collection above) <i>URCUL</i></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>BLOOD BANK</p> <p><input type="checkbox"/> ABO Rh Typing <i>ABORH</i></p> <p><input type="checkbox"/> Type and Screen <i>TSCR</i></p> <p>ADDITIONAL TEST/COMMENTS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	