

<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> <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> <hr/> <p>Physician NPI# _____</p> <hr/> <p>Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <p><input type="checkbox"/> Call critical results to phone number: (_____) _____</p> <hr/> <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: AHAVM, AHBCM, AHCY1B, HBSAG</p> <p><input type="checkbox"/> BASIC METABOLIC PANEL BMP: BUN, CA, CL, CO2, CRETI, GLU, K1, NA</p> <p><input type="checkbox"/> COMPREHENSIVE METABOLIC PANEL CMP: ALB, BUN, CA, CO2, CL, CRETI, GLU, K1, NA, TBIL, TP, ALT, ALKP, AST</p> <p><input type="checkbox"/> LIPID PANEL* LIPB: CHOL, HDL, LDLCT, TRIG</p> <p><input type="checkbox"/> HEPATIC FUNCTION PANEL* HFP: ALB, ALKP, ALT, AST, CBIL, TBIL, TP</p> <p><input type="checkbox"/> RENAL FUNCTION PANEL RFP: ALB, BUN, CA, CL, CO2, CRETI, GLU, K1, NA, PHOS</p> <p><input type="checkbox"/> OBSTETRIC SERIES (non-Medicare): ABORH, TSCR, CBCDIF, HBSAG, RUBIGG, RPR</p> <p>GENERAL LABORATORY TESTS</p> <p><input type="checkbox"/> Albumin ALB</p> <p><input type="checkbox"/> Albumin/Creatinine Ratio, Urine UACR</p> <p><input type="checkbox"/> ALT (SGPT) ALT</p> <p><input type="checkbox"/> Amylase AMYL</p> <p><input type="checkbox"/> ANA (titered if positive) ANA1</p> <p><input type="checkbox"/> AST (SGOT) AST</p> <p><input type="checkbox"/> BNP, NT Pro* NTBNP</p> <p><input type="checkbox"/> BUN BUN</p> <p><input type="checkbox"/> CA 125 * CA125</p> <p><input type="checkbox"/> CA15-3 * CA153</p> <p><input type="checkbox"/> CA19-9 * CA199</p> <p><input type="checkbox"/> Ionized Calcium ICA</p> <p><input type="checkbox"/> CBC * CBC</p> <p><input type="checkbox"/> CBC/Diff * CBCDIF</p> <p><input type="checkbox"/> CEA * CEA</p> <p><input type="checkbox"/> CRP CRP</p> <p><input type="checkbox"/> High Sensitivity CRP * HSCR</p> <p><input type="checkbox"/> Digoxin * DIG</p> <p><input type="checkbox"/> EBV Antibody Panel EBVPNL</p> <p><input type="checkbox"/> Ferritin FERR</p> <p><input type="checkbox"/> Gamma GT * GGT</p> <p><input type="checkbox"/> Glucose Fasting GLF</p> <p><input type="checkbox"/> Glucose * GLU</p> <p><input type="checkbox"/> HCG Quantitative Blood * HCGQT</p> <p><input type="checkbox"/> HCG Qualitative Urine * UHCG</p> <p><input type="checkbox"/> Hemoglobin A1C * HBA1C</p> <p><input type="checkbox"/> Hepatitis A Antibody, IgG AHAVG</p> <p><input type="checkbox"/> Hepatitis A Antibody, IgM AHAVM</p> <p><input type="checkbox"/> Hepatitis B Surface Antigen HBSAG</p> <p><input type="checkbox"/> Hepatitis C Antibody AHCY1B</p> <p><input type="checkbox"/> HIV Screen * HIV12C</p> <p><input type="checkbox"/> Iron and TIBC * IRON</p> <p><input type="checkbox"/> Lead LEAD2 Heavy Metal Demographic required</p> <p><input type="checkbox"/> Lipase LIPA</p> <p><input type="checkbox"/> Lupus Anticoag Diagnostic Interpretive Panel LUPUSP</p> <p><input type="checkbox"/> Magnesium MGI</p> <p><input type="checkbox"/> Myoglobin MYOGLB</p> <p><input type="checkbox"/> Prealbumin PREALB</p> <p><input type="checkbox"/> PSA, Diagnostic PSA</p> <p><input type="checkbox"/> PSA, Free and Total PSATF</p> <p><input type="checkbox"/> PSA Screening PSASI</p> <p><input type="checkbox"/> PT*/INR PT</p> <p><input type="checkbox"/> Activated Partial Thromboplastin Time * PTT</p> <p><input type="checkbox"/> RPR (titered if positive) RPR</p> <p><input type="checkbox"/> Syphilis Treponemal with reflex SYPHTX</p> <p><input type="checkbox"/> Sedimentation Rate, Westergren WSR</p> <p><input type="checkbox"/> T3 Total * T3</p> <p><input type="checkbox"/> T3 Free * FREET3</p> <p><input type="checkbox"/> T4 Free * FT4</p> <p><input type="checkbox"/> T4 * T4</p> <p><input type="checkbox"/> Total Bilirubin TBIL</p> <p><input type="checkbox"/> TSH * TSH</p> <p><input type="checkbox"/> Uric Acid URIC</p> <p><input type="checkbox"/> Urinalysis Only UA</p> <p><input type="checkbox"/> Urinalysis with microscopic UAWMIC</p> <p><input type="checkbox"/> Toxicology Screen, Urine * UTOX2</p> <p><input type="checkbox"/> Vitamin B12 * B12</p> <p><input type="checkbox"/> Vitamin D 25 Hydroxy * VITD</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 TRVAMP (specify: _____)</p> <p><input type="checkbox"/> <i>Bordetella Pertussis</i> DNA BORAMP</p> <p><input type="checkbox"/> <i>Clostridium Difficile</i> Toxin by PCR CDPCR</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 HSPCR</p> <p><input type="checkbox"/> Staphylococcus aureus & MRSA Screen, PCR SAPCR</p> <p><input type="checkbox"/> Group A Strep by PCR (throat) GASPCR</p> <p><input type="checkbox"/> Urine Culture * (specify method of collection above) URCUL</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 ABORH</p> <p><input type="checkbox"/> Type and Screen TSCR</p> <p>ALLERGY (IMMUNOCAP)</p> <p><input type="checkbox"/> Allergen, Expanded Respiratory Disease Profile RESPR5</p> <p>ADDITIONAL TEST/COMMENTS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	