PARKVIEW
HEALTH LABORATORIES

When faxing this Order please Fax to 260-266-8588 OR 1-877-747-3291

**Please complete all sections of the requisition**
It is the responsibility of the ordering physician to only order those tests, which are medically necessary. If multiple tests are ordered, place the number of the appropriate diagnosis next to the test. Please note: Medicare generally does not cover routine screening tests. Lab assumes patients collected by client/physician's office have accompanying assignment of benefits and release of information

Patient Soc. Sec | Additional ID

**LEAD LABEL**

Patient Legal Last Name | Patient Legal First Name | Middle .Initial

Sex | Date of birth | Age | Patient's Phone Number: | Room/Bed

Copy of Report To:

**Bill to:** [ ]Account [ ]Patient Insurance

[ ]Patient (No Insurance)

***When possible attach copies of front/back of insurance cards.**

Resp Party Soc Sec#: _____

Resp Party: _____

Resp Party Relationship:_____

Address:_____

_____

Primary Insurance: _____

Policy & Group #:_____

Secondary Insurance: _____

Policy & Group #:_____

**Print Ordering**
**PHYSICIAN:** _____
**Last, First MI**

**CLINIC:** _____

**ADDREESS**: _____

_____

**PHONE:** _____

**Authorized Signature**_____
(If signed by authorized designee, ordering physician affirms that a valid order is in the patient's office chart)

**Date Ordered** _____

Comments:

**[ ] STAT** [ ] URGENT

[ ] CALL ABNORMALS ONLY

[ ] CALL [ ] FAX

[ ] FASTING ____HRS
Time, Date of Last Dose, TDM: _____
[ ] NON- FASTING

24 HR URINE VOL._____MLS

DATE COLLECTED | TIME COLLECTED

COMMENTS: Lab Use Only:
_____VP TFN_____ SD HF CC
Drawn by:

**REASON FOR TESTING SIGNS, SYMPTOMS, DIAGNOSIS**
**********REQUIRED INFORMATION**********
ICD-9 CODES PREFERRED

(1) (5)
(2) (6)
(3) (7)
(4) (8)

| CODE | NAME | DX |
|---|---|---|
| | ******MICROBIOLOGY******* | |
| | SOURCE:_____ | |
| [ ] | CXAER AEROBIC/MISC CULT | _____ |
| [ ] | CXANA ANAEROBIC AND AEROBIC CULTURE(MISC CULTURE) | _____ |
| [ ] | CXGEN GU, FEMALE | _____ |
| [ ] | CXGUM GU, MALE | _____ |
| [ ] | CXRES RESPIRATORY CX | _____ |
| [ ] | CXSTO STOOL CULTURE | _____ |
| **[ ]** | **CXURN URINE CULTURE** | _____ |
| **[ ]** | **OCBL1 OCCULT BLD,STOOL** | _____ |
| **[ ]** | **OCBS1 OCCULT BLOOD SCREEN** | _____ |
| [ ] | OVAP PARASITOLOGY | _____ |
| [ ] | CXMRS MRSA NASAL SCREEN | _____ |
| [ ] | RNACT CHLAMYDIA BY DNA | _____ |
| [ ] | RNAGC N.GONORRHEA DNA | _____ |
| [ ] | CXBLD BLOOD CULTURE | _____ |
| | *******WRITE-IN TESTS******* | |
| [ ] | _____ | |
| [ ] | _____ | |
| [ ] | _____ | |

| CODE | NAME | DX |
|---|---|---|
| [ ] | ALB ALBUMIN | _____ |
| [ ] | ALT ALT (SGPT) | _____ |
| [ ] | AMY AMYLASE | _____ |
| **[ ]** | **PTT APTT** | _____ |
| [ ] | AST AST(SGOT) | _____ |
| [ ] | BUN BUN | _____ |
| [ ] | CA CALCIUM | _____ |
| [ ] | CBCWD CBCAutoDiff | _____ |
| **[ ]** | **CHOL CHOLESTEROL** | _____ |
| [ ] | CK CK | _____ |
| [ ] | CREAT CREATININE | _____ |
| **[ ]** | **DIG DIGOXIN** | _____ |
| [ ] | LYTES ELECTROLYTES | _____ |
| **[ ]** | **FER FERRITIN** | _____ |
| **[ ]** | **GLU GLUCOSE** | _____ |
| **[ ]** | **GLYCO GLYCO.HGB** | _____ |
| **[ ]** | **CBCND HEMOGRAM** | _____ |
| **[ ]** | **HH HGB & HCT** | _____ |
| **[ ]** | **HIV HIV** | _____ |
| **[ ]** | **IRONP IRON/TIBC** | _____ |
| **[ ]** | **LIPID LIPID PROFILE** | _____ |
| **[ ]** | **LIVER LIVER PROFILE** | _____ |
| **[ ]** | **MG MAGNESIUM** | _____ |
| [ ] | PHENB PHENOBARB | _____ |
| [ ] | PHENY PHENYTOIN | _____ |

| CODE | NAME | DX |
|---|---|---|
| [ ] | K POTASSIUM | _____ |
| [ ] | PSA PSA | _____ |
| **[ ]** | **PT PROTIME** | _____ |
| [ ] | TP PROTEIN | _____ |
| [ ] | RF RHEUMATOID FACTOR | _____ |
| **[ ]** | **ESR SED RATE** | _____ |
| **[ ]** | **T4 T4, TOTAL** | _____ |
| **[ ]** | **THYP THYROID** | _____ |
| **[ ]** | **TRSF TRANSFERRIN** | _____ |
| **[ ]** | **TRIG TRIGLYCERIDE** | _____ |
| **[ ]** | **TSH TSH** | _____ |
| [ ] | UA URINALYSIS | _____ |
| [ ] | UACI UA,**C&S IF NDICATED** | _____ |
| [ ] | UAMC2 UA W/MICROSCOPIC AND **C&S IF INDICATED** | _____ |

*NOTE: REFLEX TESTING WILL BE PERFORMED AND CHARGED WHEN INDICATED.

**NOTE: **BOLDED TESTS** REQUIRE A MEDICARE APPROVED DIAGNOSIS OR SIGNED ABN.

**PATIENT RELEASE**: I authorize the release of any medical information necessary to process claims for services rendered to myself or my dependent by Parkview Health Laboratories (including to the Centers for Medicare and Medicaid Services). I also request that payment of authorized Medicare benefits be made either to me or on my behalf to Parkview Health Laboratories for service. I acknowledge that it's my responsibility (NOT Parkview Health Laboratories') to insure that PHL is a participating provider in my insurance network. I authorize PHL to release information to any healthcare agency or facility from which I may be receiving services in the future. The question of Confidentiality among the PHL, attending physicians, family physician and patient is waived.

**CONSENT FOR SERVICE.** I authorize medical services for myself or my dependent, as determined by my physician. I authorize payment of medical benefits to PHL for laboratory testing ordered by my physician.

I have read and agree to the Patient Release Statement and the Consent for Service Patient Signature or Responsible Party _____Date:_____