Print Form

PARKVIEW HEALTH LABORATORIES

Laboratory sites listed on reverse side

LEAD LABEL

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 signatures in the client/physician office.

Patient Soc. Sec | Additional ID

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:

Ordering Physician
Printed Name: _____

Written 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:

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 #:_____

REASON FOR TESTING SIGNS, SYMPTOMS, DIAGNOSIS
**********REQUIRED INFORMATION**********
(1)
(2)
(3)
(4)
(5)

**********MICROBIOLOGY**********

SOURCE:_____

	Code	Test	Dx
☐	CXAER	AEROBIC/MISC CULT	
☐	CXANA	ANAEROBIC AND	
☐		AEROBIC/MISC.CULTURE	
☐	CXGEN	GU, FEMALE	
☐	CXGUM	GU, MALE	
☐	CXRES	RESPIRATORY CX	
☐	CXSTO	STOOL CULTURE	
☐	**CXURN**	**URINE CULTURE**	
☐	**OCBL1**	**OCCULT BLD, STOOL**	
☐	**OCBS1**	**OCCULT BLD SCRN**	
☐	OVAP	PARASITOLOGY	
☐	CXMRS	MRSA NASAL SRN	
☐	RNACT	CHLAMYDIA BY DNA	
☐	RNAGC	N.GONORRHEA DNA	
☐	CXBLD	BLOOD CULTURE	

	Code	Test	Dx
☐	ALB	ALBUMIN	
☐	ALT	ALT (SGPT)	
☐	AMY	AMYLASE	
☐	**PTT**	**APTT**	
☐	AST	AST (SGOT)	
☐	BUN	BUN	
☐	CA	CALCIUM	
☐	**CBCWD**	**CBC Auto Diff**	
☐	**CHOL**	**CHOLESTEROL**	
☐	CK	CK	

	Code	Test	Dx
☐	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	
☐	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 INDICATED**	
☐	UAMC2	UA W/MICROSCOPIC AND **C&S IF INDICATED**	

OTHER TEST REQUEST:

I have read and agree to the Patient Release Statement and the Consent for Service on the back of this form. Date: _____

Patient Signature or Responsible Party_____