

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:			Comments:	
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 _____			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/MISCCULT	
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 SCRIN	
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	LIPIDPROFILE	
LIVER	LIVERPROFILE	
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 _____