# 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 Phone Number | Room/Bed |
|---|---|---|---|---|
| | | | | |

Copy of Report To:

**Ordering Physician**
**Printed Name**: ____________________
**Written Signature**: ____________________
Must be signed by ordering Practitioner. Signature Stamps not allowed.
**Date Ordered**: ____________________

**Confidential Ward:** ____________________
**Facility Name:** ____________________
*****CONFIDENTIAL*****
ATTENTION: D.O.N.
Address of Facility: ____________________
____________________

Comments:

❑ **STAT** ❑ URGENT
❑ CALL ABNORMALS ONLY
❑ CALL ❑ FAX
❑ FASTING _____hrs
Time, Date of Last Dose, TDM:
❑ NON-FASTING
24 Hour Urine Vol. ________ml

| Date Collected | Time Collected |
|---|---|
| | |

Comments: Lab Use Only:
_____VP TFN_____
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) ____________________

| ORDERING PHYSICIAN | CODE |
|---|---|
| ❑ | |
| ❑ | |
| ❑ | |

**PLEASE NOTE: All testing performed from this order will be charged to the facility listed. Please do not use this form for routine laboratory testing.**

| CODE | NAME | DX |
|---|---|---|
| ❑ HBSAB | HEPATITIS B SURFACE Ab | _______ |
| ❑ HBSAG | HEPATITIS B SURFACE Ag | _______ |
| ❑ HEPIM | HEPATITIS IMMUNITY PANEL | _______ |
| ❑ HIV1 | HIV | _______ |
| ❑ HEPC3 | HEPATITIS C Ab | _______ |
| ❑ CXMRS | MRSA SCREEN (NASAL) | _______ |
| ❑ ____________________ | | _______ |

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

****NOTE**: CPT CODES FOR TESTS CAN BE FOUND IN THE PHL TEST DIRECTORY OR AT http://lab.parkview.com.

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

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

Patient Signature or Responsible Party: ____________________ Date: __________

6807-9 (10-12) Side 1 of 2 White - Laboratory Yellow - Client MDORDER