LABORATORY ORDER FORM

Provider Name: _____ Address: _____ Phone Number: _____ Secure Fax Number:_____ ICD 9 DIAGNOSIS CODE(s): ** REQUIRED** _____	FILL IN ALL INFORMATION Patient Name (Last, First): Date of Birth: _____ Health Record/Member ID #: _____ □ NON-FASTING □ FASTING ____ HOURS □ ROUTINE □ STAT □ ASAP

URINALYSIS
- □ UA reflex MICRO is positive
- □ Culture (reflexed as indicated)

HEMATOLOGY
- □ CBC/AUTO DIFF (man diff reflexed if meets criteria)
- □ ESR – SED RATE
- □ Hemoglobin & Hematocrit
- □ RETICULOCUTYE

COAGULATION
- □ PT PROTIME/INR

CHEMISTRY PROFILES
- □ BMP (LYTES, BUN, CREAT, GLU, CA)
- □ CMP Comp Metabolic Prof (BMP, HFP, TP)
- □ FLIPP FASTING LIPIDS
- □ IRPF Iron Panel (FE, IBC, TIBC, TRANS SAT)
- □ HFP Hepatic Function Panel
- □ LYTES (NA, K, CL, CO2)
- □ RFP (LYTES, BUN, CR, GLU, CA, ALB, PHOS)
- □ THYP FT4 reflexed if TSH abnormal high FT3 reflexed if TSH low and FT4 norm

CHEMISTRY SINGLE TESTS
- □ ALT (SGPT)
- □ AMYLASE
- □ AST (SGOT)
- □ BILIRUBIN, TOTAL – ADULT
- □ BUN
- □ CALCIUM
- □ CPK
- □ CREATININE
- □ FERRITIN
- □ FOLATE
- □ GLUCOSE
- □ HEMOGLOBIN A1C LAV
- □ POTASSIUM
- □ LIPASE
- □ MAGNESIUM
- □ MICROALB/CREAT RATIO
- □ PHOSPHORUS
- □ PTHINT INTACT PTH – Fasting preferred SST & LAV
- □ RMA RAND URINE PROT/CREAT RATION
- □ SODIUM
- □ TSH
- □ URIC ACID
- □ VITAMIN B12
- □ VITAMIN B12/FOLATE

THERAPEUTIC DRUGS

DATE AND TIME OF LAST DOSE:

- □ DIGOXIN
- □ DILANTIN (PHENYTOIN) R
- □ LITHIUM
- □ TEGRETOL (CARBAMAZEPINE)
- □ DEPAKOTE (VALPROIC ACID)
- □ VANCOMYCIN R
  □ PEAK □ TROUGH

SPECIAL CHEMISTRY
- □ RPR SYPHLIS SCREEN
- □ SPEP SERUM PROT ELECTROPHORESIS
- □ SERUM PREG (Qualitative)
- □ URINE PREG (Qualitative)
- □ BETA HCG (Qualitative)
- □ ESTRADIOL
- □ PROGESTERONE
- □ LH/FSH

24 – HOUR URINE TESTS

Total Volume Required: _____

Date of Completion: _____

- □ CRCL CREAT CLEARANCE W/SERUM
- □ UCA CALCIUM
- □ UPEP URINE PROTEIN ELECTROPHORESIS
- □ UPROT TOTAL URINE PROTEIN

OTHER

- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____
- □ _____

*****Testing ordered must be medically necessary to prevent, diagnose, or treat a medical condition.*****

THE TESTS ON THIS ORDER FORM HAVE BEEN APPROVED BU THE ATTENDING PHYSICIAN. (PLEASE SIGN/DATE BELOW).

Signature _____

Date _____