

DATE OF SERVICE \_\_\_\_\_

PRIMARY CARE PHYSICIAN (FULL NAME) \_\_\_\_\_

PATIENT SOCIAL SECURITY NO. (REQUIRED)

PATIENT'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

SEX \_\_\_\_\_ DATE OF BIRTH (REQUIRED) \_\_\_\_\_ PHONE NO. \_\_\_\_\_

GUARANTOR / SUBSCRIBER NAME (IF OTHER THAN PATIENT) \_\_\_\_\_

ADDRESS (MAILING) \_\_\_\_\_ NEW ADDRESS

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

ADDITIONAL REPORT TO: \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ SECONDARY INSURANCE \_\_\_\_\_

ID \_\_\_\_\_ ID \_\_\_\_\_

GROUP \_\_\_\_\_ GROUP \_\_\_\_\_

SUBSCRIBER \_\_\_\_\_ SUBSCRIBER \_\_\_\_\_

You must provide one or more appropriate diagnoses to substantiate all tests. When ordering tests for which Medicare reimbursements will be sought the ordering physician should only order tests that are medically necessary for the diagnosis or treatment of a patient rather than for screening purposes.

Ordering Physician - Sign, By doing so you will be attesting to the necessity of the tests you are ordering.

STAT     PHONE REPORT     FAX REPORT     URINE     NON FASTING     LAST DOSE TAKEN    DATE / TIME     COLLECTED BY    DATE / TIME

RANDOM     FASTING HOURS     24 HR \_\_\_\_\_ml

PHONE NUMBER \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

PANELS	DX-ICD	CHEMISTRY	DX-ICD	HEMATOLOGY AND COAG	DX-ICD	MICROBIOLOGY	DX-ICD
<input type="checkbox"/> BMP		<input type="checkbox"/> CRP-HS		<input type="checkbox"/> CBC w Diff		<input type="checkbox"/> O/P AG (Crypto)	
<input type="checkbox"/> CMP		<input type="checkbox"/> DEPAKOTE Level		<input type="checkbox"/> CBC w/o DIFF		<input type="checkbox"/> O/P Comp	
<input type="checkbox"/> HFP		<input type="checkbox"/> DIGOXIN		<input type="checkbox"/> Hgb		<input type="checkbox"/> Stool Qual Fat	
<input type="checkbox"/> LipidP-fasting		<input type="checkbox"/> FERRITIN		<input type="checkbox"/> HCT		<input type="checkbox"/> Lactoferrin	
<input type="checkbox"/> LYTES		<input type="checkbox"/> FOLATE		<input type="checkbox"/> PT- INR		<b>URINALYSIS</b>	<b>DX-ICD</b>
<input type="checkbox"/> PRENATAL PANEL-OB		<input type="checkbox"/> FSH		<input type="checkbox"/> PTT		<input type="checkbox"/> Urinalysis Complete	
<input type="checkbox"/> RFP		<input type="checkbox"/> GLU FASTING		<input type="checkbox"/> Retic		<input type="checkbox"/> Urine, C&S if indicated	
<b>BLOOD BANK-SEROLOGY</b>	<b>DX-ICD</b>	<input type="checkbox"/> GLU50gm-1Hr Draw		<input type="checkbox"/> WSR		<input type="checkbox"/> Urine, Culture	
<input type="checkbox"/> ABORH		<input type="checkbox"/> HCG QNT		<b>HEPATITIS SCREEN</b>	<b>DX-ICD</b>	<input type="checkbox"/> Urine Source	
<input type="checkbox"/> Type & Screen		<input type="checkbox"/> HCG QUAL		<input type="checkbox"/> Anti HBS		<input type="checkbox"/> cath, <input type="checkbox"/> clean catch	
<input type="checkbox"/> Type & Cross		<input type="checkbox"/> HGA1C		<input type="checkbox"/> HBSAG		<b>OTHER TESTS or</b>	
# of Units		<input type="checkbox"/> HIV 1,2		<input type="checkbox"/> Hep A AB		<b>SPECIAL INSTRUCTIONS</b>	
<input type="checkbox"/> Rhogam		<input type="checkbox"/> HOMOCYSTEINE		<input type="checkbox"/> Hep B Viral Qnt			
<b>CHEMISTRY</b>	<b>DX-ICD</b>	<input type="checkbox"/> IRON		<input type="checkbox"/> Hep C AB			
<input type="checkbox"/> ALB		<input type="checkbox"/> IRON + trans%Sat-IBC		<input type="checkbox"/> Hep C Geno			
<input type="checkbox"/> ALP		<input type="checkbox"/> LH		<input type="checkbox"/> Hep C PCR RNA QNT			
<input type="checkbox"/> ALT		<input type="checkbox"/> Lipase		<input type="checkbox"/> Hepatitis Panel			
<input type="checkbox"/> Ammonia		<input type="checkbox"/> MG		<b>MICROBIOLOGY</b>	<b>DX-ICD</b>		
<input type="checkbox"/> Amylase		<input type="checkbox"/> NA		<input type="checkbox"/> C Diff			
<input type="checkbox"/> ANA		<input type="checkbox"/> Procalcitonin		<input type="checkbox"/> C Stool			
<input type="checkbox"/> AST		<input type="checkbox"/> PSA-Annual Screening		source:			
<input type="checkbox"/> BILI Direct		<input type="checkbox"/> PSA-Diagnostic		<input type="checkbox"/> Culture & Sensitivity			
<input type="checkbox"/> BILI Total		<input type="checkbox"/> PSA-Free and Total		source:			
<input type="checkbox"/> Bnpep		<input type="checkbox"/> PTH Intact		<input type="checkbox"/> H Pylori Breath Test			
<input type="checkbox"/> Bun		<input type="checkbox"/> TRIGLYCERIDES		<input type="checkbox"/> H Pylori Serology			
<input type="checkbox"/> CA		<input type="checkbox"/> T3 FREE		<input type="checkbox"/> Fit Test			
<input type="checkbox"/> CEA		<input type="checkbox"/> T4 FREE					
<input type="checkbox"/> CHOL		<input type="checkbox"/> TSH-3rd Gen					
<input type="checkbox"/> CK		<input type="checkbox"/> Uric Acid					
<input type="checkbox"/> CREA		<input type="checkbox"/> Vit B12					
<input type="checkbox"/> CRP		<input type="checkbox"/> Vit D25					

**SURGICAL PATHOLOGY / BIOPSY**

SPECIMEN SOURCE  
 1 \_\_\_\_\_  
 2 \_\_\_\_\_

DIAGNOSIS / CLINICAL INFORMATION / HISTORY  
 \_\_\_\_\_  
 \_\_\_\_\_

COMMENTS / SPECIAL REQUESTS  
 \_\_\_\_\_

**PAP TEST OPTIONS:**

PAP Only

PAP w/ HPV (30 yrs and over\*)

PAP w/ Reflex HPV High Risk if ASCUS (21 to 29 years\*)

HPV Screen Only (No PAP)

Pap c CT / GC

\*See ASCCP Guidelines

**GYN CYTOLOGY**

Surepath PAP     Thinprep PAP

Source:  Vaginal     Cerv / Endo

Screening, PAP

Screening (ICD Code(s)) \_\_\_\_\_

HPV Screening (ICD Code(s)) \_\_\_\_\_

Diagnostic (ICD Code(s)) \_\_\_\_\_

LMP \_\_\_ / \_\_\_ / \_\_\_     Radiation     Hormone

Pregnant     Hysterectomy     Post Menopausal

Post Partum     CX Present     IUD

CX Absent     ABN Bleeding

Prev. Abnormal PAP(s) Date: \_\_\_\_\_ DX \_\_\_\_\_