



# Pomerene Hospital Laboratory Services

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| PATIENT INFORMATION (PLEASE PRINT)                                                                                                                                                                                                                                                                                                                                                   |  |             |                                                           |                                                                                                                                                                                                                                                     | ORDERING PROVIDER CONTACT                                               |                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Last Name                                                                                                                                                                                                                                                                                                                                                                            |  | First       | MI                                                        | Race<br><input type="checkbox"/> White / Caucasian<br><input type="checkbox"/> Black/African American<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Asian<br><input type="checkbox"/> American Indian or Alaska Native | Provider Name                                                           |                                                                                                                    |
| Address                                                                                                                                                                                                                                                                                                                                                                              |  | Birth Date  | Sex <input type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                     | Provider Signature                                                      |                                                                                                                    |
| City                                                                                                                                                                                                                                                                                                                                                                                 |  | SS#         |                                                           |                                                                                                                                                                                                                                                     | Physician NPI #                                                         |                                                                                                                    |
| State                                                                                                                                                                                                                                                                                                                                                                                |  | Zip         | Phone                                                     |                                                                                                                                                                                                                                                     | Provider Phone                                                          |                                                                                                                    |
| Hospital/Physician Office Patient ID #                                                                                                                                                                                                                                                                                                                                               |  | Accession # |                                                           |                                                                                                                                                                                                                                                     | Provider Email                                                          |                                                                                                                    |
| <small>Any physician who orders a test which may be determined to be medically unnecessary by the government may be subject to civil penalties as determined by that government agency. Appropriate ICD-10 diagnosis coding must be provided to document the necessity of testing requested. Diagnosis must also be substantiated in the patient's permanent medical record.</small> |  |             |                                                           |                                                                                                                                                                                                                                                     | <input type="checkbox"/> Call critical results to phone #: (    ) _____ |                                                                                                                    |
| INSURANCE BILLING INFORMATION (Required - Please Attach Copy of Card or Print)                                                                                                                                                                                                                                                                                                       |  |             |                                                           |                                                                                                                                                                                                                                                     | <input type="checkbox"/> Fax report to #: (    ) _____                  |                                                                                                                    |
| Bill To: <input type="checkbox"/> Hospice <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Self-Pay <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> VA <input type="checkbox"/> Other Insurance (Complete Below)                                                                                                       |  |             |                                                           |                                                                                                                                                                                                                                                     | SPECIMEN INFORMATION                                                    |                                                                                                                    |
| Primary: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child                                                                                                                                                                       |  |             |                                                           |                                                                                                                                                                                                                                                     | Collection Date: ____/____/____                                         |                                                                                                                    |
| Subscribers Last Name:                                                                                                                                                                                                                                                                                                                                                               |  | First Name: |                                                           | MI                                                                                                                                                                                                                                                  | Collection Time: _____                                                  |                                                                                                                    |
| Beneficiary/ Member #                                                                                                                                                                                                                                                                                                                                                                |  | Group #     |                                                           |                                                                                                                                                                                                                                                     |                                                                         | Specimen Type: <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood |
| Claims Address                                                                                                                                                                                                                                                                                                                                                                       |  | City        | State                                                     | Zip                                                                                                                                                                                                                                                 | <input type="checkbox"/> Other(Specify) _____                           |                                                                                                                    |
| Secondary: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, attach)                                                                                                                                                                                                                                                                                                 |  |             |                                                           | ABN: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                       |                                                                         | <input type="checkbox"/> Fasting _____ Hours <input type="checkbox"/> Non-fasting                                  |
| Diagnosis ICD Codes (MANDATORY)                                                                                                                                                                                                                                                                                                                                                      |  | 1.          | 2.                                                        | 3.                                                                                                                                                                                                                                                  | 4.                                                                      | <input type="checkbox"/> Urine Volume: _____ # Hours _____                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                      |  |             |                                                           |                                                                                                                                                                                                                                                     |                                                                         | Urine Source: <input type="checkbox"/> Random <input type="checkbox"/> Clean Catch                                 |
|                                                                                                                                                                                                                                                                                                                                                                                      |  |             |                                                           |                                                                                                                                                                                                                                                     |                                                                         | <input type="checkbox"/> Catheter <input type="checkbox"/> Suprapubic                                              |

| Chemistry                                                                                    | <input type="checkbox"/> Cortisol (7747) <b>G</b>            | <input type="checkbox"/> Potassium (1005) <b>G</b>                               | <input type="checkbox"/> Phenytoin (1051) <b>R</b>                                  | Blood Bank                                                                                                                                                  | PCR Testing                                                                                                |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Basic Metabolic Panel (1719) <b>G</b>                               | <input type="checkbox"/> Creatinine (1020) <b>G</b>          | <input type="checkbox"/> Progesterone (7765) <b>G</b>                            | <input type="checkbox"/> Phenobarbital (1301) <b>R</b>                              | <input type="checkbox"/> Cord Blood (1211) <b>P</b>                                                                                                         | <input type="checkbox"/> Group A Strep (6062) <b>E</b>                                                     |
| <input type="checkbox"/> Comp Metabolic Panel (1721) <b>G</b>                                | <input type="checkbox"/> CRP (1144) <b>G</b>                 | <input type="checkbox"/> Prolactin (4037) <b>G</b>                               | <input type="checkbox"/> Valproic Acid (7769) <b>R</b>                              | <input type="checkbox"/> Type & Screen (9065) <b>P</b>                                                                                                      | <input type="checkbox"/> Group B Strep (6063) <b>C or E</b>                                                |
| <input type="checkbox"/> Electrolyte Panel (1304) <b>G</b>                                   | <input type="checkbox"/> Estradiol (4024) <b>G</b>           | <input type="checkbox"/> PTH, Intact (4019) <b>G</b>                             | <input type="checkbox"/> Vancomycin <input type="checkbox"/> Random (7360) <b>R</b> | <input type="checkbox"/> Type & Crossmatch: <b>P</b>                                                                                                        | <input type="checkbox"/> Respiratory 4 Plex                                                                |
| <input type="checkbox"/> Hepatic Function Panel (1269) <b>G</b>                              | <input type="checkbox"/> Ferritin (7171) <b>G</b>            | <input type="checkbox"/> PSA <input type="checkbox"/> Diagnostic (7195) <b>G</b> | <input type="checkbox"/> Peak (7359) <input type="checkbox"/> Trough (7349)         | # _____ Units Packed Red Cells (9065, 1207, 1208)                                                                                                           | Includes Covid, Flu A, Flu B, RSV (4714) <b>Nasopharyngeal Swab in UTM or E</b>                            |
| <input type="checkbox"/> Hepatitis Acute Panel (4619) <b>Y</b>                               | <input type="checkbox"/> Folate(Serum) (7387) <b>G</b>       | <input type="checkbox"/> Screen (7233)                                           | <b>Hematology</b>                                                                   |                                                                                                                                                             |                                                                                                            |
| <input type="checkbox"/> Lipid Panel (1317) <b>G</b>                                         | <input type="checkbox"/> GGT (4731) <b>G</b>                 | <input type="checkbox"/> Rheumatoid Factor (7766) <b>G</b>                       | <input type="checkbox"/> CBC w/o Diff (1227) <b>L</b>                               | <b>Stool ( Sterile Container)</b>                                                                                                                           | <b>MISC.</b>                                                                                               |
| <input type="checkbox"/> Prenatal Panel * <b>P, L, Y</b>                                     | <input type="checkbox"/> FSH (6004) <b>G</b>                 | <input type="checkbox"/> Rubella (9068) <b>Y</b>                                 | <input type="checkbox"/> CBC w/ Diff (1164) <b>L</b>                                | <input type="checkbox"/> Occult Blood, Stool (Non-Cancer Screening) (1621) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 | <input type="checkbox"/> Lyme AB Early with Reflex ( $\leq 30$ days of signs and symptoms) (4047) <b>Y</b> |
| <input type="checkbox"/> Renal Panel (1727) <b>G</b>                                         | <input type="checkbox"/> Glucose (1012) <b>G</b>             | <input type="checkbox"/> Sodium (1004) <b>G</b>                                  | <input type="checkbox"/> Sed Rate (1069) <b>L</b>                                   | <input type="checkbox"/> Ova & Parasites, Stool (4632) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3                     | <input type="checkbox"/> Lyme AB Late with Reflex (> 30 days of signs and symptoms) (4046) <b>Y</b>        |
| <input type="checkbox"/> Thyroid Panel (T4, T3u, FT4) <b>Y</b>                               | <input type="checkbox"/> Glucose Tolerance ____ HR <b>GR</b> | <input type="checkbox"/> T3, Free (4000) <b>Y</b>                                | <input type="checkbox"/> PT & INR (1292) <b>B</b>                                   | <input type="checkbox"/> C.diff Toxin A&B (9493)                                                                                                            |                                                                                                            |
| <input type="checkbox"/> TSH w/ Reflex to FT4 (1368) <b>Y</b>                                | <input type="checkbox"/> hCG Qualitative (1228) <b>R</b>     | <input type="checkbox"/> T3, Total (4021) <b>Y</b>                               | <input type="checkbox"/> APTT (1296) <b>B</b>                                       | <input type="checkbox"/> Fecal Lactoferrin (1539)                                                                                                           |                                                                                                            |
| <input type="checkbox"/> Vitamin B12 + Folate(9496) <b>Y</b>                                 | <input type="checkbox"/> hCG Quantitative (1267) <b>G</b>    | <input type="checkbox"/> T3, Uptake (1024) <b>Y</b>                              | <input type="checkbox"/> D-Dimer (7347) <b>B</b>                                    |                                                                                                                                                             |                                                                                                            |
| <input type="checkbox"/> Albumin (1057) <b>G</b>                                             | <input type="checkbox"/> HbCAb Qualitative (4596) <b>Y</b>   | <input type="checkbox"/> T4, Free (7316) <b>Y</b>                                | <b>Urine (Sterile or 24 hr. Container)</b>                                          |                                                                                                                                                             |                                                                                                            |
| <input type="checkbox"/> ALP (1018) <b>G</b>                                                 | <input type="checkbox"/> HBSAb Quantitative (4194) <b>Y</b>  | <input type="checkbox"/> T4, Total (1025) <b>Y</b>                               | <input type="checkbox"/> Urinalysis (1393)                                          | <b>Blood Cultures</b>                                                                                                                                       | <b>Sexual / Women's Health</b>                                                                             |
| <input type="checkbox"/> ALT (SGPT) (1034) <b>G</b>                                          | <input type="checkbox"/> HBSAG Qualitative (4004) <b>Y</b>   | <input type="checkbox"/> Thyroid Perox. Ab ( 4009) <b>Y</b>                      | <input type="checkbox"/> hCG Qualitative Urine (1229)                               | <input type="checkbox"/> Blood Cultures (1122) <b>BCB</b>                                                                                                   | <input type="checkbox"/> GC/Chlamydia (4617) <b>A</b>                                                      |
| <input type="checkbox"/> Amylase (1001) <b>G</b>                                             | <input type="checkbox"/> Hemoglobin A1C (2159) <b>L</b>      | <input type="checkbox"/> TSH (1266) <b>Y</b>                                     | <input type="checkbox"/> Urine Culture (1513)                                       | <b>Culture Other (e-swab)</b>                                                                                                                               | <input type="checkbox"/> HIV Combo(4673) <b>G</b>                                                          |
| <input type="checkbox"/> AST (SGOT) (1011) <b>G</b>                                          | <input type="checkbox"/> Insulin (7763) <b>G</b>             | <input type="checkbox"/> Testosterone ( 7132) <b>G</b>                           | <input type="checkbox"/> Creat. Clearance (0548) <b>G</b>                           | <b>Source:</b>                                                                                                                                              | <input type="checkbox"/> Syphilis (4495) <b>Y</b>                                                          |
| <input type="checkbox"/> BNP, NT Pro (2156) <b>G</b>                                         | <input type="checkbox"/> Iron (1028) <b>Y</b>                | <input type="checkbox"/> Transferrin (4079) <b>G</b>                             | Height: ____ Weight: ____                                                           | Antibiotic Therapy:                                                                                                                                         | <input type="checkbox"/> Thin Prep PAP (1938) <b>T</b>                                                     |
| <input type="checkbox"/> BUN (1007) <b>G</b>                                                 | <input type="checkbox"/> Iron &TIBC (2161) <b>Y</b>          | <input type="checkbox"/> Uric Acid (1008) <b>G</b>                               | <input type="checkbox"/> Microalbumin Random (7536)                                 | <input type="checkbox"/> ID/ w Sensitivity                                                                                                                  | <input type="checkbox"/> Thin Prep HPV DNA (1923) <b>T</b>                                                 |
| <input type="checkbox"/> Bilirubin, Direct (1042) <b>G</b>                                   | <input type="checkbox"/> PTH Intact (4019) <b>Y</b>          | <input type="checkbox"/> Vitamin B 12 (7148) <b>G</b>                            | <input type="checkbox"/> Microalbumin w/ Creatinine (0547)                          | <b>Body Fluid (Sterile Container)</b>                                                                                                                       | <input type="checkbox"/> Thin Prep HPV DNA W/ Reflex (1932) <b>T</b>                                       |
| <input type="checkbox"/> Bilirubin, Total (1002) <b>G</b>                                    | <input type="checkbox"/> LDH (1010) <b>G</b>                 | <input type="checkbox"/> Vitamin D 25 (7193) <b>Y</b>                            | <input type="checkbox"/> Urine Creatinine (1023)                                    | <b>Type:</b>                                                                                                                                                | <b>Other Testing List Below</b>                                                                            |
| <input type="checkbox"/> Bilirubin Conjugated/ Unconj. (neonates less than 14 days) <b>G</b> | <input type="checkbox"/> Lactate (7560) <b>G</b>             | <input type="checkbox"/> Vitamin D 1,25 (4050) <b>Y</b>                          | <input type="checkbox"/> Urine Creat /Protein Ratio (9013)                          | <input type="checkbox"/> Cell count (1106)                                                                                                                  |                                                                                                            |
| <input type="checkbox"/> Calcium (1016) <b>G</b>                                             | <input type="checkbox"/> Lipase (7071) <b>G</b>              | <b>Drug Monitoring</b>                                                           |                                                                                     | <input type="checkbox"/> Crystals (7407)                                                                                                                    |                                                                                                            |
| <input type="checkbox"/> Cholesterol, Total (1048) <b>G</b>                                  | <input type="checkbox"/> Lithium (1689) <b>Y</b>             | <input type="checkbox"/> Carbamazepine (1692) <b>R</b>                           | Urine Electrolytes: <input type="checkbox"/> Sodium(9288)                           | <input type="checkbox"/> Protein (4259)                                                                                                                     |                                                                                                            |
| <input type="checkbox"/> CK, Total (1009) <b>G</b>                                           | <input type="checkbox"/> Magnesium (1685) <b>G</b>           | <input type="checkbox"/> Digoxin (1027) <b>R</b>                                 | <input type="checkbox"/> Potassium (9285) <input type="checkbox"/> Chloride (7268)  | <input type="checkbox"/> Glucose (4258)                                                                                                                     |                                                                                                            |
|                                                                                              | <input type="checkbox"/> Phosphorous (1684) <b>G</b>         | <input type="checkbox"/> Levetiracetam (4031) <b>R</b>                           | Urine Protein                                                                       | <input type="checkbox"/> Gram Stain (9259)                                                                                                                  |                                                                                                            |
|                                                                                              |                                                              |                                                                                  | <input type="checkbox"/> Random (1337) <input type="checkbox"/> 24 hour (1241)      |                                                                                                                                                             |                                                                                                            |

|            |                         |           |                          |          |                     |          |                           |                                                      |
|------------|-------------------------|-----------|--------------------------|----------|---------------------|----------|---------------------------|------------------------------------------------------|
| <b>B</b>   | Blue ( Sodium Citrate)  | <b>GR</b> | Grey (Potassium Oxalate) | <b>R</b> | Red (Serum no gel)  | <b>A</b> | Aptima Collection Device  | * CBC, Type and Screen, Hep B SAG, Rubella, Syphilis |
| <b>BCB</b> | Blood Culture Bottle    | <b>L</b>  | Lavender (EDTA)          | <b>Y</b> | Yellow Top (SST)    | <b>C</b> | Cepheid Collection Device |                                                      |
| <b>G</b>   | Green (Lithium Heparin) | <b>P</b>  | Pink (EDTA)              | <b>T</b> | Preservcvt Pap Vial | <b>E</b> | E- swab                   |                                                      |