



PATIENT & TEST INFORMATION			ACCOUNT INFORMATION	
Patient Name (Last, First, Middle Initial)		Date of Birth	*Facility: _____ STAT	
		/ /	*Physician's Full Name: _____ <input type="checkbox"/>	
Fasting <input type="checkbox"/>	Sex	Social Security #	Notes: _____	
Non-fasting <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F			
Collection Date	Collection Time	Location / Special Info:		
/ /	A M			
Bill to: <input type="checkbox"/> Account/Patient <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid Ins #: _____				

ICD-10 DIAGNOSIS CODES

Limited Coverage tests/panels (MLCT) require an ICD code. Advance Beneficiary Notice required if condition not covered by applicable ICD code.

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|---|--|---|---|
| <input type="checkbox"/> Abd. Pain (R10.9) | <input type="checkbox"/> Cough (R05) | <input type="checkbox"/> Fever (R50.2) | <input type="checkbox"/> Renal Failure (N19) |
| <input type="checkbox"/> Anemia Unspec. (D50.9) | <input type="checkbox"/> Coumadin Therapy (Z79.01) | <input type="checkbox"/> Hyperchol. (E78.0) | <input type="checkbox"/> Seizure Disorder (R56.9) |
| <input type="checkbox"/> Arrhythmia (I49.9) | <input type="checkbox"/> CVA-Stroke (I67.89) | <input type="checkbox"/> Hyperlipids (E78.5) | <input type="checkbox"/> SOB (R06.02) |
| <input type="checkbox"/> Arthritis/General (M12.9) | <input type="checkbox"/> Depression (F32.9) | <input type="checkbox"/> Hypertension (I10) | <input type="checkbox"/> UTI (N59.0) |
| <input type="checkbox"/> ASHD (I25.10) | <input type="checkbox"/> Dehydration (E86.0) | <input type="checkbox"/> Hyperthyroid (E05.90) | <input type="checkbox"/> Vitamin D Deficiency (E55.9) |
| <input type="checkbox"/> Atrial Fibrillation (I48.91) | <input type="checkbox"/> Diabetes, Type I (E10.9) | <input type="checkbox"/> Hypothyroidism (E03.9) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> BPH (N41.9) | <input type="checkbox"/> Diabetes, Type II (E11.9) | <input type="checkbox"/> Monitoring Meds (Z79.899) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cellulitis (L03.90) | <input type="checkbox"/> Diarrhea (R19.7) | <input type="checkbox"/> Nausea w/ vomiting (R11.2) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest Pain (R07.9) | <input type="checkbox"/> Dizziness/Vertigo (R42) | <input type="checkbox"/> Palpitations (R00.2) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Congestive Heart Fail. (I50.9) | <input type="checkbox"/> Dysuria (R30.0) | <input type="checkbox"/> Pneumonia (J18.8) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> COPD (J44.9) | <input type="checkbox"/> Fatigue (R53.83) | <input type="checkbox"/> PSA Elevation (R97.2) | <input type="checkbox"/> Other _____ |

ORGAN / DISEASE PANELS	THERAPEUTIC DRUGS	MISCELLANEOUS TESTING	
<input type="checkbox"/> Basic Metabolic Panel (BMP)	<input type="checkbox"/> Carbamazepine/Tegretol (TEG)	<input type="checkbox"/> Albumin (ALB)	<input type="checkbox"/> Iron, TIBC w/ % Sat. (IRONIBC)
<input type="checkbox"/> Comp. Metabolic Panel (CMP)	<input type="checkbox"/> Digoxin (DIG)	<input type="checkbox"/> Alk. Phos. (AP)	<input type="checkbox"/> LDH (LDH)
<input type="checkbox"/> Electrolyte Panel (LYTES)	<input type="checkbox"/> Dilantin (DIL)	<input type="checkbox"/> ALT (SGPT) (ALT)	<input type="checkbox"/> Lipase (LIPA)
<input type="checkbox"/> Hepatic Function Panel (LIV)	<input type="checkbox"/> Lithium (LI)	<input type="checkbox"/> Ammonia, Plasma (AMM)	<input type="checkbox"/> Magnesium (MG)
<input type="checkbox"/> Lipid Panel (LIP)	<input type="checkbox"/> Phenobarbitol (PHE)	<input type="checkbox"/> Amylase (AMY)	<input type="checkbox"/> Occult Blood (OB)
<input type="checkbox"/> Renal Panel (RENAL)	<input type="checkbox"/> Valproic Acid (Depakote) (DEP)	<input type="checkbox"/> AST (SGOT) (AST)	<input type="checkbox"/> Ova + Parasite Exam (OP)
THYROID TESTING	URINE TESTING	<input type="checkbox"/> Bilirubin, Direct (DBILI)	<input type="checkbox"/> Potassium (K)
<input type="checkbox"/> T3 Uptake (T3)	<input type="checkbox"/> Drug Abuse Test (12 Panel) (DOA12)	<input type="checkbox"/> Bilirubin, Total (TBILI)	<input type="checkbox"/> Prealbumin (PALB)
<input type="checkbox"/> Free T3 (FT3)	<input type="checkbox"/> Microalbumin (MA)	<input type="checkbox"/> Blood Culture (BC)	<input type="checkbox"/> Protein, Total (TP)
<input type="checkbox"/> T4, Total (T4)	<input type="checkbox"/> UA (UA) - Collect. Method: _____	<input type="checkbox"/> BUN (BUN)	<input type="checkbox"/> Protime + CreatU (PCU)
<input type="checkbox"/> Free T4 (FT4)	<input type="checkbox"/> Urine Culture and Sensitivity (UC)	<input type="checkbox"/> BNP (BNP)	<input type="checkbox"/> PSA, Total (PSA)
<input type="checkbox"/> TSH (TSH)		<input type="checkbox"/> C-Diff (CDIFF)	<input type="checkbox"/> Sputum (Lower Respiratory Cult.) (SPC)
HEMATOLOGY & COAGULATION	IMMUNO. TESTING	<input type="checkbox"/> Cholesterol (CHOL)	<input type="checkbox"/> Stool Culture (STC)
<input type="checkbox"/> CBC w/ Diff. (CBC)	<input type="checkbox"/> BHCG Pregnancy Qualitative (BHCG)	<input type="checkbox"/> CK Total (CK)	<input type="checkbox"/> Testosterone, Total (TEST)
<input type="checkbox"/> Hemoglobin (HGB)	<input type="checkbox"/> BHCG Quantitative (QBHCG)	<input type="checkbox"/> CK-MB (CKMB)	<input type="checkbox"/> Thin PREP PAP (TPP)
<input type="checkbox"/> Hemoglobin/Hematocrit (HH)	<input type="checkbox"/> CRP (CRP)	<input type="checkbox"/> Creatinine (CREA)	<input type="checkbox"/> Triglycerides (TRIG)
<input type="checkbox"/> Hematocrit (HCT)	<input type="checkbox"/> Flu A & B Screen (FLU)	<input type="checkbox"/> DHEAS (DHEAS)	<input type="checkbox"/> Troponin (TRO)
<input type="checkbox"/> Platelet Count (PLT)	<input type="checkbox"/> Hep. B Surface Ag (HBSAG)	<input type="checkbox"/> Estradiol (EST)	<input type="checkbox"/> Vancomycin P/T (VANPT)
<input type="checkbox"/> Protime / INR (PT)	<input type="checkbox"/> Hep. B Surface Ab (Immunity) (HPSAB)	<input type="checkbox"/> Ferritin (FER)	<input type="checkbox"/> Vancomycin Peak (VANP)
<input type="checkbox"/> PTT (PTT)	<input type="checkbox"/> HIV Screen (HIV)	<input type="checkbox"/> Folate (FOL)	<input type="checkbox"/> Vancomycin Trough (VANT)
<input type="checkbox"/> Sed. Rate (WSR)	<input type="checkbox"/> H. Pylori (HPYLORI)	<input type="checkbox"/> FSH (FSH)	<input type="checkbox"/> Uric Acid (URIC)
<input type="checkbox"/> WBC (WBC)	<input type="checkbox"/> Mono Test (MONO)	<input type="checkbox"/> LH (LH)	<input type="checkbox"/> Vitamin B12 (B12)
	<input type="checkbox"/> Rapid Strep Screen (STREP)	<input type="checkbox"/> GGT (GGT)	<input type="checkbox"/> Vitamin D (VD)
	<input type="checkbox"/> RPR Screen (RPR)	<input type="checkbox"/> Glucose (GLU)	<input type="checkbox"/> Wound Culture (WC)
	<input type="checkbox"/> Rubella (Immunity) (RUB)	<input type="checkbox"/> HDL Cholesterol (HDL)	PANELS
		<input type="checkbox"/> Hemoglobin A1C (A1C)	<input type="checkbox"/> Arthritis Panel
		<input type="checkbox"/> Iron (FE)	(ESSR, CRP, ANA, Uric Acid, RF)

OTHER TESTS: _____ For Medicare patients, please select only tests which are medically necessary for the diagnosis or treatment of the patient.

I hereby authorize the Springs Medical Lab or any associated reference lab to perform laboratory services on the above patient. I am an authorized medical provider/personnel.

Physician's/Authorized Signature	Date	Entered by	Verified by	For office use only:
				Accession #