

Patient & Test Information				Account Information			
Patient Name (Last, First, M.I.)			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Facility: _____			<input type="checkbox"/> STAT
<input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting	Date of Birth		Soc. Security #				
Address		State	Zip				
Coll. Date	Coll. Time AM PM	Phone					
ICD-9 Diagnosis Codes				Billing Information			
When Ordering Tests for Medicare Patients, Please Select Only Tests which are Medically Necessary for the Diagnosis or Treatment of the Patient.				Bill To: <input type="checkbox"/> Account <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Patient			
___ Abd. Pain 789.00                      ___ Fatigue 780.79 ___ Anemia Unspec. 280.1                ___ Fever 780.6 ___ Arrhythmia 427.9                      ___ Headache 784.0 ___ Arthritis/General 716.90              ___ Heartburn 787.1 ___ ASDH 414.00                            ___ Hyperchol. 272.0 ___ Atherosclerosis 440.90                ___ Hyperlipids 272.4 ___ Atrial Fibrillation 427.31              ___ Hypertension 401.1 ___ BPH 601.9                                ___ Hypertension-Unspec. 401.9 ___ Bronchitis 490                          ___ Hyperthyroid 242.90 ___ Cellulitis 682.9                         ___ Hypertrig 272.1 ___ Chest Pain 786.5                        ___ Hypothyroidism 244.9 ___ Congestive Heart Fail. 428.0        ___ Liver Dysf. 573.9 ___ COPD 496                                 ___ Lymph Nodes Enlarged 785.6 ___ Cough 786.2                             ___ Monocleosis 075 ___ CVA-Stroke 436                         ___ Nausea w/ vomiting 787.01 ___ Depression 311                         ___ Nausea 787.02 ___ Dehydration 276.5                      ___ Palpitations 785.1 ___ Diabetes, Type I 250.01                ___ Pneumonia 486 ___ Diabetes, Type II 250.00                ___ Pylonephritis 590.1 ___ Diarrhea 787.91                         ___ Renal Failure 586 ___ Diarrhea NOS 558.9                     ___ Seizure Disorder 780.39 ___ Dizziness/Vertigo 780.4                ___ Syncope 780.2 ___ Dyspnea 786.09                         ___ TIA 435.9 ___ Dysuria 788.1				Insurance Name or Guarantor			
				Billing Address			
City		State	Zip	Insured Name		Group#	
Insured ID# / Medicare# / Medicaid#		Relationship to Insured		Additional ICD-9 Codes:			
___ Other: _____		___ Other: _____		___ Other: _____		___ Other: _____	
Limited Coverage tests/panels (MLCT) require an ICD code. Advance Beneficiary Notice required if condition not covered by applicable ICD code.							
ORGAN/DISEASE PANELS		THERAPEUTIC DRUGS		MISCELLANEOUS TESTING			
___ Basic Metabolic Panel		___ Carbamazapine (Tegretol)		___ Albumin		___ PSA, total	
___ Comprehensive Metabolic Panel		___ Digoxin		___ Alk. Phos.		___ PSA, Free	
___ Electrolyte Panel		___ Dilantin		___ ALT (SGPT)		___ Testosterone, Total	
___ Hepatic Function Panel		___ Lithium		___ Amylase		___ Triglycerides	
___ Lipid Panel		___ Valproic Acid (Depakote)		___ AST (SGOT)		___ Uric Acid	
___ Renal Panel		URINE TESTING		___ Bilirubin, Direct		___ Vitamin B12	
THYROID TESTING		___ Urinalysis		___ Bilirubin, Total		___ Vitamin D	
___ T3 Uptake		___ Urine Culture and Sensitivity		___ BUN		___ Other _____	
___ T4 Total		___ Urine Culture and Sensitivity		___ BNP		___ Other _____	
___ Free T4		___ Drugs of Abuse Screen		___ Cholesterol		___ Other _____	
___ TSH		___ Nicotine Screen		___ CK Total		___ Other _____	
___ FTI		___ Microalbumin		___ Creatinine		___ Other _____	
HEMATOLOGY & COAGULATION		IMMUNO. TESTING		___ CRP		___ Other _____	
___ CBC w/ Diff.		___ BHCG (Pregnancy) qual.		___ Ferritin		___ Other _____	
___ Hemoglobin (Hgb)		___ Mono Test		___ Folate		___ Other _____	
___ Hematocrit (Hct)		___ Rapid Strep Screen		___ GGTP		___ Other _____	
___ Platelet Count		___ RPR Screen		___ Glucose		___ Other _____	
___ Prottime w/ INR		___ Rubella (Immunity)		___ HDL Cholesterol		___ Other _____	
___ PTT		___ HIV Screen		___ Hemoglobin A1C		___ Other _____	
___ Sed. Rate (WSR)		___ Hep. B Surface Ag		___ Iron		___ Other _____	
___ WBC		___ Hep. B Surface Ab (Immunity)		___ Iron, TIBC w/ % Sat.		___ Other _____	
		___ H. Pylori		___ Lipase		___ Other _____	
				___ Protien, Total		___ Other _____	
Other Tests:							
I hereby authorize the release of medical information to the service described herien and authorize payment directly to The Springs Medical Lab. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my helath care insurer.							
/ /							
Patient's Signature				Physician's/Authorized Signature		Date	