

Patient Last Name	First	M.I.	Date of Birth	Sex	Patient Phone Number
PATIENT STREET ADDRESS			CITY	STATE	ZIP
Patient ID No.	DATE COLLECTED	TIME COLLECTED	OTHER		



DELANO REGIONAL MEDICAL CENTER
 1401 GARCES HIGHWAY
 DELANO, CA 93216-0460
 Phone 661-721-5278
 Phone 800-999-5562
 Songlin Liang, MD
 Director of Pathology & Laboratory Medicine

BILLING INFORMATION PLEASE CHECK APPROPRIATE BOX WITH COMPLETE INFORMATION.

<input type="checkbox"/> BILL DOCTOR	<input type="checkbox"/> BILL PATIENT
<input type="checkbox"/> BILL MEDICARE	MEDICARE SUFFIX ABN ATTACHED <input type="checkbox"/> YES <input type="checkbox"/> NO Initials
<input type="checkbox"/> BILL MEDICAL	MEDICAL NO. SUBSCRIBER NO. GROUP NO.
<input type="checkbox"/> BILL OTHER/PPC	PLAN NAME/INSURANCE ADDRESS
<input type="checkbox"/> BILL IPA/HMO	PLAN - PLEASE MARK "X" IN APPROPRIATE BOX AND PROVIDE INSURANCE CARRIER AND MEMBER ID#

I hereby authorize the release of medical information related to the service described herein and authorize payment directed to LabCorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X Patient's Signature Date

MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)

DRMC will cross reference all test CPT codes with your submitted ICD-9 codes. Tests requiring an ABN will be charged to the patient and the patient will be asked to sign the ABN notice.

All orders for clinical laboratory tests must include ICD-9 or narrative diagnosis for the Medical reason for those tests. If a test is not supported by documentation in the medical record or is for screening, the test must be designated as Screening Test.

DX 1 _____ DX2 _____ DX3 _____ DX4 _____

5. Screening Test - Patient will be asked to sign an ABN accepting financial responsibility. One Annual screening for PSA and Occult Blood will be billed to Medicare.

STAT ASAP ROUTINE

PROFILES & PANELS

See Reverse For Panel Components

<input type="checkbox"/> ELECTROLYTE PANEL	80051
<input type="checkbox"/> BASIC METABOLIC PANEL	80048
<input type="checkbox"/> RENAL FUNCTION PANEL	80069
<input type="checkbox"/> COMP. METABOLIC PANEL	80053
<input type="checkbox"/> LIPID PANEL (Should be Fasting)	80061
<input type="checkbox"/> HEPATIC FUNCTION PANEL	80076
<input type="checkbox"/> HEPATITIS PANEL	80074
<input type="checkbox"/> HYPOTHYROID PROFILE	84443/84436/84479
<input type="checkbox"/> PRENATAL PANEL	80055
CBC Rubella T&S (ABO/RH/Antibody Screen)	
RPR HBSAG HIV (signed consent)	
<input type="checkbox"/> TOXICOLOGY SCREEN (Amp, Barb, Coc, Marj, Benz, PCP, Opiates, TCA)	80100

HORMONES

<input type="checkbox"/> ESTRADIOL/ESTRIOL	82670/82677
<input type="checkbox"/> FSH	83001
<input type="checkbox"/> LH	83002
<input type="checkbox"/> PROGESTERONE	84144
<input type="checkbox"/> TESTOSTERONE TOTAL	84403

IMMUNOLOGY / SEROLOGY

<input type="checkbox"/> ANA	86038
<input type="checkbox"/> ASO Titer/Screen	86060/86063
<input type="checkbox"/> COCCI Serology	86171/86331
<input type="checkbox"/> HIV Ab Sc (Attach Consent)	86701
<input type="checkbox"/> H. Pylori Serum Qual	86677
<input type="checkbox"/> Monospot	86308
<input type="checkbox"/> RA, Qual	86430
<input type="checkbox"/> RPR	86592
<input type="checkbox"/> Rapid Strep A	87880
<input type="checkbox"/> Rapid RSV	87807
<input type="checkbox"/> Urine Pregnancy	81025

URINALYSIS

Urine Type <input type="checkbox"/> Mid <input type="checkbox"/> Cath <input type="checkbox"/> Pedibag	
<input type="checkbox"/> UA, COMPLETE (WITHOUT REFLEX)	81001
<input type="checkbox"/> UA, COMPLETE (REFLEX TO CULTURE)	81001/87008
<input type="checkbox"/> UA, COMPLETE + URINE CULTURE	81101/87088
<input type="checkbox"/> MicroAlbumin Random	82043
<input type="checkbox"/> MicroAlbumin/Creat Ratio	82043/82570

CHEMISTRY

<input type="checkbox"/> Ammonia	82140
<input type="checkbox"/> Amylase	82150
<input type="checkbox"/> BNP (B-Natriuretic peptide)	83880
<input type="checkbox"/> Bili. Neonatal	82247
<input type="checkbox"/> Bili. Direct	82248
<input type="checkbox"/> Bili. Total	82247
<input type="checkbox"/> BUN	84520
<input type="checkbox"/> Calcium	82310
<input type="checkbox"/> CEA	82378
<input type="checkbox"/> Cholesterol	82465
<input type="checkbox"/> CK Total	82550
<input type="checkbox"/> CK Total (Reflex to CKMB if elevated)	82550
<input type="checkbox"/> CK MB	82553
<input type="checkbox"/> CREAT	82565
<input type="checkbox"/> Folate	82746
<input type="checkbox"/> Ferritin	82728
<input type="checkbox"/> Glucose Fasting	82947
<input type="checkbox"/> Glucose RANDOM	82947
<input type="checkbox"/> Glucose Tolerance: (up to 3 spec. includes glucose)	82951
<input type="checkbox"/> Glucose (ea additional beyond 3)	82952
<input type="checkbox"/> Glucose 1 Hr. post 50 gms	82947
<input type="checkbox"/> GGT	82977
<input type="checkbox"/> Glycated HGB (A1C)	83036
<input type="checkbox"/> Iron	83540
<input type="checkbox"/> TIBC (Iron Binding)	83550
<input type="checkbox"/> Lipase	83690
<input type="checkbox"/> Magnesium	83735
<input type="checkbox"/> Phos	84100
<input type="checkbox"/> Potassium	84132
<input type="checkbox"/> PSA	84153
<input type="checkbox"/> PSA (PSA Annual Screen - once per year per Medicare. Circle #5 above in diagnosis section.)	G0103
<input type="checkbox"/> Quantitative HCG Titer	84702
<input type="checkbox"/> Serum Preg (Pos/Neg)	84703
<input type="checkbox"/> SGOT/AST	84450
<input type="checkbox"/> SGPT/ALT	84460
<input type="checkbox"/> Thyroxine (T4)	84436
<input type="checkbox"/> T3 Uptake	84479
<input type="checkbox"/> TSH	84443
<input type="checkbox"/> Troponin	84484
<input type="checkbox"/> Uric Acid	84550
<input type="checkbox"/> Urine Creatinine Clearance (24 hr)	82575
<input type="checkbox"/> Vitamin B12	82607

THERAPEUTIC DRUGS

(Time of Last Dose: _____)

<input type="checkbox"/> Digoxin (Draw 6 hours after dose)	80162
<input type="checkbox"/> Dilantin/Phenytoin	80185
<input type="checkbox"/> Lithium	80178
<input type="checkbox"/> Phenobarb	80184
<input type="checkbox"/> Theophylline	80198
<input type="checkbox"/> Tegretol/Carbamazepine	80156
<input type="checkbox"/> Valproic/Dipropylacetic Acid	80164

COAGULATION

<input type="checkbox"/> D-Dimer	85379
<input type="checkbox"/> Fibrinogen	85384
<input type="checkbox"/> PFA	85576
<input type="checkbox"/> PTT	85730
<input type="checkbox"/> PT	85610

HEMATOLOGY

<input type="checkbox"/> CBC w/Autodiff 5 Part	85025
<input type="checkbox"/> Sed Rate Manual	85651
<input type="checkbox"/> Hemogram w/PLTS	85027
<input type="checkbox"/> Retic, Auto	85045
<input type="checkbox"/> Manual Diff	85007

MICROBIOLOGY

SOURCE: _____

Collection date & time: _____

<input type="checkbox"/> Do Not Reflex to Sensitivity Antibiotics in Use	
<input type="checkbox"/> Do Not Reflex to Sensitivities if culture is positive	
<input type="checkbox"/> Chlamydia/GC direct probe	87485/87590
<input type="checkbox"/> Chlamydia/GC Urine; Amp	87491/87591
<input type="checkbox"/> Culture Blood (x _____)	87040
<input type="checkbox"/> Culture Genital	
<input type="checkbox"/> Vaginal	87070
<input type="checkbox"/> Endocervix	87070
<input type="checkbox"/> Culture Sputum	87070
<input type="checkbox"/> Culture Stool	87045
<input type="checkbox"/> Culture Strep Screen Throat	87081
<input type="checkbox"/> Culture Urine w/cc	87088
<input type="checkbox"/> Giardia Antigen	88874
<input type="checkbox"/> Gram Stain	87205
<input type="checkbox"/> Group B Strep Vag/Rectal	87081
<input type="checkbox"/> H. Pylori - Stool AG	87338
<input type="checkbox"/> Influenza A&B	87400
<input type="checkbox"/> MRSA Screen (nasal pharyngeal)	87081
<input type="checkbox"/> Occult Blood (x _____)	82270
____ (Occult Blood - once per year per Medicare. Circle #5 above in diagnosis section.)	
<input type="checkbox"/> Ova/Parasites	87177/87209
<input type="checkbox"/> C.Difficile Culture (REFLEX TO CELL TOXINS) (A&B)	87075
<input type="checkbox"/> C.DIFFICILE TOXINS (A&B)	87230
<input type="checkbox"/> C.DIFFICILE TOXINS (A&B)	87230

OTHER

Test Name	

STANDING ORDER (up to 1 year) From _____ to _____ Physician Signature _____ Date _____

PHYSICIAN ACKNOWLEDGEMENT AND CERTIFICATION:
 The above signed physician certifies for the Hospital/Laboratory that either: 1. The tests ordered are medically necessary and specific tests ordered on the requisition are necessary for the diagnosis and treatment of the patient the physician is treating the patient in connection with the diagnoses or complaints listed on this requisition; the information on this requisition accurately reflects the medical reasons for requesting the specific test ordered on this requisition; and the medical necessity or each of the individual test ordered on this requisition is appropriately documented in the patient's medical record; or, 2. The tests ordered are for purposes of screening that the physician believes is appropriate for the patient even though the payor may not allow reimbursement for the tests; and the fact that payment is likely to be denied by Medicare or other payors has been explained to the patient, who has agreed to pay for the test personally by signing Advance Beneficiary Notice (ABN).