

Physician Name: _____

Address _____

Phone # _____

Phone Report _____

Fax Report _____

Patient Name _____		LAST	FIRST
Address _____			
M	F	DOB _____	SS# _____ Phone _____
Physician Name _____		Date Collected _____	Time Collected _____ INITIAL _____
Physician Signature _____		<input type="checkbox"/> Phone Report _____	<input type="checkbox"/> Fax Report _____
CC: _____		<input type="checkbox"/> STAT _____	<input type="checkbox"/> Fasting _____ <input type="checkbox"/> Random _____
Please attach copy (Front and Back) of insurance card			
DIAGNOSIS (REQUIRED) 1) _____ 2) _____ 3) _____ 4) _____			

PANELS	TESTS	MICROBIOLOGY
Electrolyte (LYTES) (Na, K, Cl, CO ₂ , Anion Gap) Hepatitis Panel Acute (HEPAP) (HAAb, HBcoreAb, HBsAg, HCAb) Renal Function Panel (RENAL) (Lytes, Glucose, BUN, Creat, Alb, Ca, Phos) Basic Metabolic Panel (MET10) (Lytes, Ca, Glu, BUN, Creat, BUN/Creat, Calc, Osmol) Lipid Profile (LIPID) (Chol, Trig, HDL, HDL/LDL ratio.) Comp. Metabolic Panel (CMP) (BMP, T. Prot, Alb, Alk. Phos, AST, ALT, T. Bili, Glob, Alb/Glob ratio) Prenatal Panel (PRPAN) (CBC, HBsAG, Rubella, RPR, ABO, Rh, Antibody screen) Hepatic Function Panel (LIVER) (Alb, T. Bili, D. Bili, Alk. Phos, T. Protein, AST, ALT, Glob, A/G ratio)	__ Folate (FOLAT) __ FSH (FSH) __ GGT (GGT) __ Glucose (GLU) __ Glucose 1hr PG (Preg) (GLPGP) (50 grams) __ Glucose Tol. 3hr (Preg) (GT3P) (100 grams) (Fasting 1, 2, 3 hr) __ Glucose Tol. 2hr (Preg) (GTT2) (75 grams) (Fasting 1, 2 hr) __ Glucose Tol. 2hr (DM) (GTT2D) (75 grams) (Fasting 2 hr) __ Glucose Tol. 3hr (DM) (GTT3) (75 grams) (Fasting 1, 2, 3 hr) __ H.Pylori stool Ag (HPSA) __ HCG Quant (HCGQ) __ Hemoglobin A1C (HA1C) __ Hemogram (HEMO) __ Hep B Core Ab (HBCAB) __ Hep B Core Ab IgM (HEBCO) __ Hep B Surface Ab (HBSAB) __ Hep A Ab Total (HAAB) __ Hep A Ab IgM (HAABM) __ Hep C Ab (HCAB) __ Hep B Surface Ag (HBS) __ HIV-1 antibody screen (EHIV) <small>Signed informed consent on file in patient medical record (Please Initial)</small> __ Homocystine (HOMO2) __ IEP with Immunofix (IEP) __ Insulin Fasting (INSF) __ Iron (IRON) __ T. Binding Cap (FETIB) __ Lipoprotein (a) (LIPOA)	__ Lead, whole blood (LEAD) __ Luteinizing Hormone (LH) __ Microalbumin (UMAR) __ Occult blood stool (FOBI) __ Ova & Parasite stool (OVAP) __ Phenytoin (Dilantin) (DILAN) __ Phosphorus (PHOS) __ Prolactin (PROL) __ Protein electrophoresis (PEP) __ Protein-24hr urine (UTP24) __ Prothrombin time (PT) __ PTT (PTT) __ Pregnancy, urine (UHCG) __ Progesterone (PROG) __ PSA (PSA) __ PTH-intact (PTH) __ RPR (RPRSL) __ Sed Rate-Westergren (WESR) __ T Cell Lymph enum (TCEL2) __ Testosterone (TESTO) __ Thyroid Screen- TSH (TSHP) <small>(Abnormal TSH reflex to FT4)</small> __ Thyroxine, Free (FT4) __ Thyroxin, Total (T4) __ Triglycerides (TRIG) __ TSH (TSH) __ Urinalysis (UA) __ UA + Cult if indicated (UACIF) __ Uric Acid (URIC) __ Valproic Acid (VALP) __ Vitamin B12 (B12)
		SOURCE _____ __ AFB Culture & Smear (CXAFB) __ Blood Culture (CXBLD) __ Body Fluid Culture (CXFLD) __ Ear Culture (CXEAR) __ Eye Culture (CXEYE) __ Fungal, Blood Culture (CXFNB) __ Fungal, Skin Culture (CXFNS) __ Fungus Culture & Smear (CXFUN) <small>(Other Sources)</small> __ Genital Culture (CXGEN) __ GC/Chlam-Amp.DNA Probe (GCCH) <small>(Genital or Urine)</small> __ Grp A Strep- Throat Culture (CXGRA) __ Grp B Strep-Vaginal Culture (CXGRB) __ Grp B Strep -Vaginal Culture (CXSBP) <small>(Penicillin Allergic)</small> __ Herpes Culture (HSV) __ Respiratory Culture (CXRES) __ Respiratory Culture, CF (CXCFR) <small>(Cystic Fibrosis)</small> __ Stool Culture (CXSTO) __ Urine Culture (CXURN) __ Wound Culture, Skin (CXWNS) <small>(Skin Surface, Skin or Rash)</small> Aerobic Only __ Wound Culture, Deep (CXWND) <small>(Deep Wound, Tissue or Abscess)</small> Aerobic & Anaerobic <small>* Please note routine cultures include Gram Stain for sources where it is appropriate. Sensitivity testing is performed on a predominate organism as indicated by organism ID & specimen source.</small>

Blood Bank

Additional Laboratory Tests Comments:

__ Type & Screen (complete section below)
 __ Rhogam Workup (complete section below)
 Date of Rhogam _____
 Gestational Age _____