100B

TO PRE-REGISTER, CALL 667-6326 OR 1-888-922-9633
or www.mclaren.org/bayregion/onlinepreregistration

☐ STAT - EXPEDITE RESULTS TO:_______________
☐ Fax ☐ Call (Number) _______________

PATIENT INFORMATION

PATIENT NAME ☐ MALE ☐ FEMALE
STREET ADDRESS
CITY | STATE | ZIP CODE
SOCIAL SECURITY NUMBER | DATE OF BIRTH | PATIENT TELEPHONE NUMBER

OTHER DIAGNOSIS IF NOT LISTED BELOW: _______________

BILLING INFORMATION

PRIMARY INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ OTHER — PATIENT IS: ☐ SUBSCRIBER ☐ SPOUSE ☐ OTHER
INSURANCE COMPANY NAME
INSURANCE MEMBER / ID # | GROUP #
INSURANCE ADDRESS | SUBSCRIBER NAME
MEDICARE / MEDICAID # | SUBSCRIBER DOB

SECONDARY INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ OTHER — PATIENT IS: ☐ SUBSCRIBER ☐ SPOUSE ☐ OTHER
INSURANCE COMPANY NAME
INSURANCE MEMBER / ID # | GROUP #
INSURANCE ADDRESS | SUBSCRIBER NAME
MEDICARE / MEDICAID # | SUBSCRIBER DOB

DIAGNOSIS CODES MUST BE MEDICALLY APPROPRIATE FOR THE PATIENT'S CONDITION AND CONSISTENT WITH DOCUMENTATION IN THE PATIENT'S MEDICAL RECORD

☐ R94.5 ABNORMAL LIVER FUNCTION STUDIES
☐ R10.9 ABDOMINAL PAIN UNSPCF SITE
☐ N91.2 ABSENCE OF MENSTRUATION
☐ D64.9 ANEMIA NOS
☐ M25.50 ARTHALGIA/JOINT PAIN
☐ I25.10 ASHD NOS
☐ J459.09 ASTHMA
☐ I48.91 ATRIAL FIBRILLATION
☐ R03.0 BLOOD PRESSURE, HIGH
☐ K92.1 BLOOD IN STOOL
☐ N40.0 BPH, BENIGN PROSTATIC HYPERTROPHY
☐ N72 CERVICITIS
☐ R07.9 CHEST PAIN
☐ J44.9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
☐ D68.9 COAGULATION DEFECTS
☐ Z12.11 COLORECTAL SCREENING, COLON
☐ Z12.12 COLORECTAL SCREENING, RECTUM
☐ I50.9 CONGESTIVE HEART FAILURE
☐ K59.00 CONSTIPATION
☐ I25.10 CORONARY ARTERY DISEASE
☐ R05 COUGH
☐ E11.9 DIABETES MELLITUS
☐ R197 DIARRHEA
☐ R42 DIZZINESS AND GIDDINESS
☐ R30.0 DYSURIA
☐ R60.9 EDEMA
☐ E87.8 ELECTROLYTE IMBALANCE
☐ R53.83 FATIGUE AND MALAISE
☐ R56.00 FEBRILE CONVULSIONS
☐ R50.9 FEVER
☐ K52.9 GASTROENTERITIS
☐ K21.9 GERD
☐ M10.9 GOUT
☐ R51 HEADACHE
☐ R31.9 HEMATURIA
☐ K75.9 HEPATITIS
☐ E34.9 HORMONE IMBALANCE
☐ E78.00 HYPERCHOLESTEROL
☐ R73.9 HYPERGLYCEMIA
☐ E78.5 HYPERLIPIDEMIA/DYSLIPIDEMIA
☐ I10 HYPERTENSION, BENIGN
☐ I10 HYPERTENSION, ESSENTIAL
☐ E05.90 HYPERTHYROIDISM
☐ E16.2 HYPOGLYCEMIA OVER AGE 28 DAYS
☐ E03.9 HYPOTHYROIDISM
☐ P59.9 JAUNDICE NEWBORN
☐ R17 JAUNDICE, UNSPECIFIED
☐ Z79.01 LONG TERM USE OF ANTICOAGULANTS
☐ Z79.899 LONG TERM USE OF OTHER MEDS
☐ R11.0 NAUSEA ALONE
☐ R11.2 NAUSEA WITH VOMITING
☐ E66.9 OBESITY NOS
☐ Z34.90 PREGNANCY
☐ N41.9 PROSTATITIS
☐ N40.1 PROSTATE ENLARGED(BPH) W/URIN. OBSTR.
☐ Z12.5 PSA SCREEN
☐ N28.9 RENAL & URETHERAL DIS NOS
☐ R56.9 SEIZURE NOS
☐ R06.02 SHORTNESS OF BREATH
☐ J02.9 SORE THROAT
☐ R55 SYNCOPE AND COLLAPSE
☐ Z51.81 THERAPEUTIC DRUG MONITORING
☐ E07.9 THYROID DISORDER
☐ J06.9 URI (UPPER RESPIRATORY)
☐ R32 URINARY INCONTINENCE
☐ N39.0 URINARY TRACT INFECTION
☐ N76.0 VAGINITIS OR VULVITIS
☐ N89.8 VAGINAL DISCHARGE
☐ E55.9 VITAMIN D DEFICIENCY
☐ R11.10 VOMITING ALONE
☐ R63.4 WEIGHT LOSS

☐ PATIENT SHOULD BE **FASTING**_______ HOURS, NOTHING TO EAT OR DRINK PRIOR TO BLOOD DRAWING ☐♦ 12 HRS. ☐♦♦ 8 HRS.

SAMPLE COLLECTION DATE / TIME

ORGAN / DISEASE PANELS

- ☐ **ELECTROLYTE PANEL** (Na, K, Cl, CO2)
- ☐ **HEPATIC (LIVER) FUNCTION PANEL** (Alb, TBili, DBili, AP, AST, ALT, TP)
- •☐ **BASIC METABOLIC PANEL** (Na, K, Ca, Cl, C02, Glu, BUN, Cr) ♦♦
- •☐ **COMP METABOLIC PANEL** (Na, K, Cl, C02, Glu, BUN, Cr, Ca, TP, Alb, TBili, AP, AST, ALT) ♦
- F•☐ **LIPID PANEL** (Fasting Specimen) (TChol, Trig, HDL, calc LDL) ♦
- ☐ **OBSTETRIC PANEL W/REFLEX** (ABO/Rh, Antibody Scr RBC, CBC, RPR, HbsAg, Rubella IgGAb)
- •☐ **RENAL FUNCTION PANEL** (Alb, BUN, Ca, CO2, Cl, CR, Glu, Phos, K, Na)
- ☐ **HEPATITIS PANEL ACUTE W/REFLEX** (HBsAg w/reflex confirm, HCAb, HA AbIgM, HBcAbIgM)

OTHER TESTS:

OTHER TESTS

- ☐ ALBUMIN
- ☐ ALK PHOS
- ☐ AMYLASE
- ☐ ANA
- ☐ B-12 ☐ FOLATE ♦♦
- •☐ BETA 2 MICROGLOBULIN
- ☐ BILIRUBIN TOTAL
- ☐ BILIRUBIN DIRECT
- •☐ BNP PRO
- ☐ BUN
- •☐ CA 125
- ☐ CALCIUM
- F•☐ CEA
- F•☐ CHOLESTEROL TOT. ♦♦
- F•☐ CHOLESTEROL HDL ♦♦
- F•☐ CHOLESTEROL LDL ♦♦
- ☐ CPK
- •☐ CK-MB
- ☐ CREATININE WITH GFR
- ☐ CRP
- F•☐ CRP, HIGH SENS.
- •☐ DIGOXIN
- ☐ DILANTIN
- ☐ ELECTROPHORESIS ☐ SERUM ☐ URINE
- •☐ ESR WESTEGREN
- •☐ FERRITIN
- ☐ FSH ☐ LH
- F•☐ GGTP (GGT)
- F• GLUCOSE: ☐ FASTING ☐ RANDOM
- F•☐ GLUCOSE TOL ___HR ☐ OB SCRN 1 HR 50 GM
- F•☐ HCG, BETA SUB UNIT TUMOR MARKER
- F•☐ DIRECT LDL
- F•☐ HEMOGLOBIN A1C
- •☐ HEP B SURFACE AG
- •☐ HEP C VIRUS AB
- F•☐ HIV
- •☐ IFE SERUM
- ☐ IFE URINE
- ☐ IGG ☐ IGA ☐ IGM
- •☐ IRON
- •☐ IRON BINDING CAP.
- ☐ LDH
- ☐ LEAD
- ☐ LIPASE
- •☐ MAGNESIUM
- ☐ MONO
- ☐ PHOSPHOROUS
- ☐ POTASSIUM
- F•☐ PREGNANCY (QUAL) ☐ SERUM ☐ URINE
- ☐ PROTEIN TOTAL
- F•☐ PSA Diagnostic
- F•☐ PSA Screen, Reflex Free PSA if indicated
- ☐ RA
- •☐ RPR
- ☐ RUBELLA ANTIBODIES, IgG
- ☐ SGOT (AST)
- ☐ SGPT (ALT)
- ☐ SODIUM
- •☐ TRANSFERRIN
- F•☐ TSH
- F•☐ T-4 FREE
- ☐ THEOPHYLLINE
- F•☐ TRIGLYCERIDE ♦
- ☐ URIC ACID
- F•☐ VitD, 25 HYDROXY

HEMATOLOGY / BLOOD BANK

- ☐ ABO/RH TYPING
- ☐ TYPE AND SCREEN
- •☐ HEMOGLOBIN
- •☐ HEMATOCRIT
- •☐ CBC WITH DIFF
- •☐ CBC WITHOUT DIFF
- ☐ PLATELET FUNCTION TEST
- ☐ PLAVIX EFFECT ON PLATELETS
- F•☐ PT WITH INR
- •☐ PTT, ACTIVATED
- •☐ RETIC
- •☐ SED RATE

URINE

- ☐ Urinalysis Reflex Microscopic if Pos
- ☐ Urinalysis with Microscopic
- •☐ Urinalysis with Microscopic, Culture if Indicated
- ☐ PROTEIN 24HR
- ☐ CREATININE CLEARANCE 24HR
- •☐ U MICROALB + ALB/CREA RATIO

STOOL

- F•☐ OCCULT BLD
- F• OCCULT BLD SCR, COLON DX: Z12.11
- F• OCCULT BLD SCR, RECTUM DX: Z12.12
- •☐ OVA & PARASITES x _____

MICROBIOLOGY

- ☐ ROUTINE CULTURE / SOURCE (REQUIRED):_______________
- •☐ URINE CULTURE / MIDSTREAM
- •☐ URINE CULTURE / CATH
- ☐ GRAM STAIN
- ☐ THROAT CULTURE
- ☐ CHLAMYDIA / GC AMPLIFIED DNA PROBE / PCR
- ☐ STREP A SCREEN CULTURE / THROAT
- ☐ CHLAMYDIA / PCR
- ☐ RAPID STREP A ANTIGEN / THROAT
- ☐ GC/PCR
- ☐ GENITAL CULTURE / SOURCE (REQUIRED):_______________
- ☐ STOOL CULTURE (SHIG, SAL, CAMPY, E COLI 157, VIBRIO)
- ☐ OTHER (SPECIFY):_______________

NOTE: ID & SUSCEPTIBILITIES PERFORMED AS INDICATED W/ADDITIONAL CHARGE

SIGNATURE OF PHYSICIAN ▶ X | DATE SIGNED | TIME | **COPY OF REPORT TO:**

For any patient of any payer (including Medicare and Medicaid), only order those tests which are medically necessary for the diagnosis and treatment of the patient.

BAY REGION

• TESTS MAY REQUIRE ADVANCED BENEFICIARY NOTICE (ABN)
F • FREQUENCY LIMITS MAY REQUIRE ABN

LABORATORY OUTPATIENT TEST REQUEST FORM
LABORATORY PHONE (989) 894-3752 FAX (989) 894-5744

L-686 1/19

White: LABORATORY Canary: RETAIN IN OFFICE