# BAY REGION
# LABORATORY OUTPATIENT TEST REQUEST FORM

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

☐ STAT - EXPEDITE RESULTS TO: ____________

☐ Fax ☐ Call (Number) ____________

**LABORATORY PHONE (989) 894-3752 FAX (989) 894-5744**
• TESTS MAY REQUIRE ADVANCED BENEFICIARY NOTICE.

## PATIENT INFORMATION

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

## BILLING INFORMATION

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

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

**ICD CODES ARE REQUIRED FOR INSURANCE BILLING. THE CODES PROVIDED ARE NOT ALL-INCLUSIVE; CONSULT THE ICD-10 MANUAL FOR A COMPLETE LISTING.**

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ N91.2 | ABSENCE OF MENSTRUATION | ☐ R30.0 | DYSURIA | ☐ Z34.90 | PREGNANCY | ☐ N39.0 | URINARY TRACT INFECTION |
| ☐ D64.9 | ANEMIA NOS | ☐ E78.0 | HYPERCHOLESTEROLEMIA | ☐ 020.0 | THREATENED ABORTION | ☐ N76.0 | VAGINITIS OR VULVITIS |
| ☐ N72 | CERVICITIS | ☐ N92.0 | MENORRHAGIA | ☐ 060.03 | THREATENED PRETERM LABOR, 3RD TRI | ☐ N89.8 | VAGINAL DISCHARGE |
| ☐ N93.8 | DUB | ☐ R10.2 | PELVIC PAIN | ☐ 060.02 | THREATENED PRETERM LABOR, 2ND TRI | ☐ OTHER | ____________ |

☐ 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, CO2, Glu, BUN, Cr) ◆◆
•☐ **COMP METABOLIC PANEL** ◆ (Na, K, Cl, CO2, 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)

## OTHER TESTS

☐ ANTIBODY SCREEN
☐ B-12 ☐ FOLATE ◆◆
•☐ Beta-hCG (Quant.-Serum)
☐ BUN
☐ CALCIUM
•☐ CBC WITH DIFF
•☐ CBC WITHOUT DIFF
F•☐ CHOLESTEROL TOT. ◆◆
F•☐ CHOLESTEROL HDL ◆◆
F•☐ CHOLESTEROL LDL ◆◆
☐ CREATININE WITH GFR
☐ ESTRADIOL
•☐ FERRITIN
☐ FETAL FIBRONECTIN
☐ FSH ☐ LH
• GLUCOSE:
☐ FASTING ☐ RANDOM
F•☐ GLUCOSE TOL
____ HR ☐ OB SCRN 1 HR 50 GM
☐ HEP B SURFACE AG
☐ HEP C VIRUS AB
☐ HERPES TYPE I & TYPE II, IgG & IgM
☐ OTHER
F•☐ HIV
•☐ IRON •☐ IRON BINDING CAP.
•☐ MAGNESIUM
☐ POTASSIUM
F•☐ PREGNANCY (QUAL.)
☐ SERUM ☐ URINE
☐ PROGESTERONE
☐ PROLACTIN
•☐ RPR
☐ RhoGam
☐ RUBELLA ANTIBODIES, IgG
☐ SGOT (AST) ☐ SGPT (ALT)
☐ TYPE & SCREEN
F•☐ THYROID CASCADE
F•☐ TSHF F•☐ T-4 FREE
☐ URIC ACID
☐ URINALYSIS Reflex Microscopic if Pos
☐ Urinalysis with Microscopic
☐ Urinalysis with Microscopic
• Culture if Indicated
☐ URINE DRUG SCREEN
☐ VARICELLA ZOSTER-IgG & IgM

## ☐ ALPHA-FETOPROTEIN (AFP) SCREEN

(AFP Maternal/Estriol, Unconjugated/hCG, Total/hCG, Free alpha-subunit)

Birth Date__________ Weight _______ Lbs./Kg. _______

Insulin Dependent Diabetic? ☐ Yes ☐ No — Select yes if patient was on insulin prior to this pregnancy

Race: ☐ Black ☐ Other

Twin Pregnancy? ☐ Yes ☐ No — Risk estimates are not available for triplets or Diabetic twin pregnancies. If one twin is deceased, select No

In-Vitro Fertilization? ☐ Yes ☐ No Donor DOB:__________ (if other than Patient)

If frozen egg or embryo used, how long frozen:______ Years ______ Months

Has patient had previous pregnancy with Down Syndrome (trisomy21) or other trisomy? ☐ Yes ☐ No

Is this a repeat serum Screen? ☐ Yes ☐ No

If yes, previous control number __________

EDD________ By_____ U/S or ____ LMP — Ultrasound dating increases screening performance. - Required for twins.

NTD assessment not available before 15 weeks by ultrasound; 16-18 weeks preferred.
Down Syndrome & Trisomy 18 assessment available 14 weeks, 0 days - 22 weeks 6 days.

## MICROBIOLOGY

ROUTINE CULTURE / SOURCE (REQUIRED): __________

☐ CHLAMYDIA/GC DNA PROBE
☐ CHLAMYDIA DNA PROBE/PCR
☐ STREP SCREEN CULTURE
•☐ URINE CULTURE MIDSTREAM
☐ VAGINAL CULTURE
☐ HPV
☐ GC DNA PROBE/PCR
☐ THROAT CULTURE
•☐ URINE CULTURE CATH
☐ VIRAL CULTURE

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

| SIGNATURE OF PHYSICIAN X | DATE SIGNED | COPY OF REPORT TO: |
|---|---|---|

• Test may require advanced beneficiary notice (ABN)
F• Frequency limits may require ABN

ADDRESSOGRAPH

100B

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WC-0004 07/16 ORIGINAL: MEDICAL RECORD CANARY: LABORATORY