**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Collection Info**

Date: \_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient fasting? Yes / No Hours Fasting: \_\_\_\_\_\_\_\_

Who are we billing? (Circle One)

Patient (Insurance) / Facility

**Diagnosis Code (ICD-10):**

**(Required when billing patient’s insurance)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ordering Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Last Name, First Name)**

**Ordering Provider Address:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Send Additional Reports To:**

**1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Note: Please attach patient‘s demographics***

\_\_\_ Basic Metabolic Panel (**MINI**) SS

\_\_\_ CBC with automated Diff (**CBC**) LH

\_\_\_ Comp Metabolic Panel (**CMET**) SS

\_\_\_ CRP (**CRP**) SS

\_\_\_ Folate/B12 (**FOB12**) SS

\_\_\_ Hemoglobin/Hematocrit (**HBHCT**) LH

\_\_\_ Hemoglobin A1C (**GLYCO**) LH

\_\_\_ Iron/Ferritin/Transferrin (**ITF**) SS

\_\_\_ Lipid Panel (**LIPSC**) SS

\_\_\_ Magnesium (**MG**) SS

\_\_\_ Phosphorus (**PHOS**) SS

\_\_\_ PSA (**PSAD**) SS

\_\_\_ Protime/INR (**PT**) BB

\_\_\_ PTT (**PTT**) BB

\_\_\_ Renal Function Panel (**RFP**) SS

\_\_\_ Sed Rate, Automated (**SEDR**) LH

\_\_\_ T4, Free (**FT4**) SS

\_\_\_ TSH (**TSH**) SS

\_\_\_ Vancomycin (**VANR/VANT**) SS

Circle one: Trough / Random

\_\_\_ Vitamin D, 25 Hydroxy (**VITAD**) SS

\_\_\_ UA with Culture if Indicated Urine

**Circle one: VOID / CATH**

\_\_\_ Urine Culture Only (**URC**) Urine

\_\_\_ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Highlighted tests may require Advance Beneficiary Notice**

