SAVE Reset Form

LABORATORY OUTPATIENT TESTING

OUTPATIENT LABORATORY HOURS: MONDAY - FRIDAY 7am - 7pm SATURDAY 8am - 2pm SUNDAY - CLOSED - EMERGENCIES: PLEASE CALL 802-388-4747

LOCATION

HOSPITAL USE ONLY

HOSPITAL NO.

BILLING NO.

B | FRZ | RED | TGR | LAV

COPY TO: (COMPLETE NAME AND ADDRESS)

REQ. NO. | ENTERED | VERIFIED

PATIENT NAME (LAST, FIRST)

DATE OF BIRTH | SEX | SOCIAL SECURITY NO. XXX-XX-

ADDRESS (STREET)

CITY | STATE | ZIP CODE

Additional Instructions:

BILLING INFORMATION OR ATTACH FACE SHEET ☐

RESPONSIBLE PARTY NAME | PHONE NO.

ADDRESS (STREET / CITY / STATE / ZIP CODE)

MEDICARE NO. | MEDICAID NO. | STATE

INSURANCE COMPANY NAME | CERT. NO. | GROUP NO.

INSURANCE COMPANY ADDRESS | RELATIONSHIP

SUBSCRIBER NAME | EMPLOYER

SIGNATURE REQUIRED TO BILL INSURANCE

I HEREBY AUTHORIZE RELEASE OF INFORMATION: I hereby authorize Porter Hospital, Inc., to release information regarding the medical history, treatment or benefits payable for this claim to the insurance carrier(s) or its authorized representatives. If patient is a minor, I authorize testing on minor child. ON FILE NOT ACCEPTABLE

Signature:

X

SPECIMEN INFORMATION

Before I collected this sample, I verified with the patient ALL information on this form and patient/parent/guardian has signed this form if insurance is to be billed.

COLLECTION DATE | TIME | BY | FASTING ☐ YES ☐ NO

SPECIMEN TYPE: ☐ BLOOD ☐ URINE

OTHER _____

☐ FAX RESULTS FAX # _____

☐ CALL RESULTS CALL # _____

HEMATOLOGY/ COAGULATION

- ☐ CBC
- ☐ CBC with DIFF
- ☐ ESR - Sed Rate
- ☐ PT
- ☐ PTT
- ☐ Retic Count

URINE ☐ Clean Catch ☐ Cath

URINALYSIS
- ☐ UA Routine √
- ☐ UA w/Microscopic
- ☐ UA Positive do C&S √

- ☐ Microalbumin
- ☐ Urine Culture √
- ☐ Drug Screen @ Porter

STOOL/FECAL TESTING

- ☐ GA/Crypto AG

OCCULT BLOOD
- ☐ Diagnostic
- ☐ Screening Only

- ☐ Ova & Parasites
- ☐ Stool Culture √
- ☐ CDIFF Toxin

MICROBIOLOGY

Specify site for any test ordered below:
Site:_____

- ☐ CHL DNA Probe
- ☐ GC DNA Probe
- ☐ RAPID GRP A STREP√
- ☐ PHARYNGEAL CUL √
- ☐ GRP B STREP PCR

Herpes PCR
- [ ]Simplex
- [ ]Varicella

- ☐ Routine Culture √

GENERAL TESTS

- ☐ A1C
- ☐ ANA √
- ☐ BNP
- ☐ CRP-HS (Cardiac)
- ☐ CRP-Quant
- ☐ Ferritin
- ☐ Folate
- ☐ Glucose Tol * (2 hr)

HCG
- ☐ Pregnancy
- ☐ Tumor

- ☐ Hepatitis Panel
  - ☐ Hep A AB √
  - ☐ Hep B Surface AB
  - ☐ Hep B Surface AG √
  - ☐ Hep C AB
- ☐ HIV √
- ☐ Iron
- ☐ Iron/IBC/% Sat
- ☐ Lyme AB √

PSA
- ☐ Diagnostic
- ☐ Screening
- ☐ Total & Free

- ☐ Rheumatoid Factor

THYROID TESTING
- ☐ Cascade √
- ☐ TSH
- ☐ T4 Free
- ☐ Total T3

- ☐ Testosterone, Total
  - ☐ Total & Free
- ☐ Transferrin
- ☐ Vitamin B12
- ☐ Vitamin D 25-OH

MISCELLANEOUS

_____ _____

_____ _____

_____ _____

_____ _____

TESTING WILL NOT BE PERFORMED WITHOUT THE APPROPRIATE DIAGNOSIS CODE(S) OR NARRATIVE AND THE SIGNATURE OF THE ORDERING PROVIDER.

REASON FOR TESTS / ICD-10 CODES

CLINICIAN'S SIGNATURE **(Required)** DATE

ORDER PANEL ➧

ORDER INDIVIDUAL TESTS ➧

	☐ ELECTROLYTES	☐ BMP †	☐ CMP †	☐ RENAL †	☐ HEPATIC	☐ LIPID *
☐ Albumin			●	●	●	
☐ Alkaline Phosphatase			●		●	
☐ ALT/SGPT			●		●	
☐ Amylase						
☐ AST/SGOT			●		●	
☐ Bilirubin (Direct)					●	
☐ Bilirubin (Total)			●		●	
☐ BUN		●	●	●		
☐ Calcium		●	●	●		
☐ Chloride	●	●	●	●		
☐ Cholesterol (Total)						●
☐ CO2 (Total)	●	●	●	●		
☐ CPK						
☐ Creatinine		●	●	●		
☐ GGT						
☐ Glucose †		●	●	●		
☐ HDL Cholesterol						●
☐ LDH (Total)						
☐ LDL Cholesterol-Direct						√
☐ Lipase						
☐ Magnesium						
☐ Phosphorous				●		
☐ Potassium	●	●	●	●		
☐ Protein (Total)			●		●	
☐ Sodium	●	●	●	●		
☐ Triglycerides *						●
☐ Uric Acid						

See www.porterhospitallab.org for additional information. † - Fasting AM draw preferred * - Requires 12 hour fast (only water allowed)

√ **Tests may reflex to additional testing.** Reflexed tests, if required, will be performed, reported and billed unless indicated here:
NO REFLEX TESTING_____.

REQ

The University of Vermont Health Network - Porter Medical Center
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