



## Request for Outpatient Laboratory Services

### Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Insurance Provider \_\_\_\_\_ Policy # \_\_\_\_\_

Pre-certification:  Not Required  In Progress  Completed Pre-Cert/Authorization# \_\_\_\_\_

### Reason for Test

REASON FOR THE TEST MUST BE GIVEN. (Please DO NOT USE "Rule Out" or "Possible/Probable?")

ICD codes AND diagnostic information must be provided for EACH test ordered.

Outpatient Testing or Procedure Order \_\_\_\_\_

Reason/Diagnosis \_\_\_\_\_

ICD Code(s) \_\_\_\_\_

### Order/Results (Orders are valid for 90 days.)

Requested Test Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  ROUTINE (at patient's convenience)  URGENT w/in 48 hours  STAT

Results  Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_  Call (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Laboratory Test (Single)			Point of Care Test (Single)	
<input type="checkbox"/> COVID Antibody	<input type="checkbox"/> Lipase	<input type="checkbox"/> ABO/Rh	<input type="checkbox"/> Fingerstick Glucose	
<input type="checkbox"/> COVID PCR	<input type="checkbox"/> Lipid Panel	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Urine Drug Screen (10 Panel)	
<input type="checkbox"/> Rapid COVID	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Ammonia	<b>Panels</b>	
<input type="checkbox"/> Rapid Flu/COVID	<input type="checkbox"/> Triglycerides	<input type="checkbox"/> ESR	<input type="checkbox"/> Basic Metabolic	
<input type="checkbox"/> Rapid Flu	<input type="checkbox"/> HA1C	<input type="checkbox"/> CRP	<input type="checkbox"/> Comprehensive Metabolic	
<input type="checkbox"/> Rapid Strep	<input type="checkbox"/> Fe & TIBC	<input type="checkbox"/> Uric Acid Level	<input type="checkbox"/> Hepatic	
<input type="checkbox"/> Rapid RSV	<input type="checkbox"/> TSH	<input type="checkbox"/> Phenytoin Total	<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Complete Blood Count	<input type="checkbox"/> T3	<input type="checkbox"/> Valproic Acid Level	<input type="checkbox"/> Pre-Operative	CBC, CMP, RH Factor, PT INR, aPTT.
<input type="checkbox"/> Urinalysis-Routine	<input type="checkbox"/> Free T4	<input type="checkbox"/> Prothrombin Time with INR (PT/INR)	<input type="checkbox"/> STD	GC, Chlamydia, Trich., BV
<input type="checkbox"/> Urinalysis-Culture	<input type="checkbox"/> Thyroid Screen (FT4 & TSH)	<input type="checkbox"/> Troponin I	<input type="checkbox"/> Thyroid	TSH, FT3, FT4, T3 Uptake
<input type="checkbox"/> Urine Pregnancy Qual.	<input type="checkbox"/> PT	<input type="checkbox"/> Other:		
<input type="checkbox"/> Serum Pregnancy Quant.	<input type="checkbox"/> PTT			
<input type="checkbox"/> D-Dimer	<input type="checkbox"/> Rh			
<input type="checkbox"/> Lactate Level (CG4)				

### Physician Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ NPI# \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Notice: Topeka ER & Hospital is unable to bill Medicare, Medicaid for services rendered.

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