114825.939 Order Requisition Blank

Copy of version 3.0 (approved and current)

Last Approval or Periodic Review Completed	6/23/2023	**Controlled Copy**	ID 313664
Next Periodic Review Needed On or Before	6/23/2025	**Location**	Test Catalog
Effective Date	7/1/2021	**Organization**	Great River Health System

Approval and Periodic Review Signatures

Type	Description	Date	Version	Performed By	Notes
Periodic review	Designated Reviewer	6/23/2023	3.0	Alexander Pederson MD	
Approval	Lab Director	6/23/2021	3.0	Alexander Pederson	
Approval	Administrative Director	6/22/2021	3.0	Natalie Sailors	

Signatures from prior revisions are not listed.

Version History

Version	Status	Type	Date Added	Date Effective	Date Retired
3.0	Approved and Current	Major revision	6/21/2021	7/1/2021	Indefinite

Linked Documents

- 114825.345 Laboratory Quality Assurance Plan

Southeast Iowa Regional Medical Center Laboratory

West Burlington Campus 1221 S. Gear Avenue West Burlington IA 52655/FM Campus 5445 Avenue O, Fort Madison Iowa 52627

Phone: West Burlington Campus-(319) 768-4527 Scheduling (319) 768-3577 Fort Madison Campus- (319)376-2020 Scheduling (319)376-2841

DATE: / / SSN: ______-_____-_______	**BILL TO:** ☐ **PATIENT** ☐ **FACILITY :** ___________________
NAME: (Last) (First) (M.I.)	☐ MEDICARE #
	☐ MEDICAID #
DATE OF BIRTH: / / SEX: ☐ M ☐ F	☐ COMMERCIAL INSURANCE Company Name: ______________________ Company Address: ______________________
UNIT/ROOM:	Subscriber's Name: Subscriber SSN: ________-_______-_________
ORDERING PHYSICIAN/PROVIDER:	Policy # Subscriber DOB: / /
DATE OF DRAW REQUESTED: TIME DRAWN:	Group # Group Name:
DIAGNOSIS/ICD10 CODE(S):	Subscriber's Relationship to Patient:
	Guarantor's Name: Guarantor DOB: / /

PLEASE MAKE SURE SPECIMENS ARE LABELED WITH THE PATIENT'S FULL NAME AND BIRTHDATE

Please include subscriber's address if different than patient

Patient is: ☐ Fasting ☐ Non-Fasting

PANELS

- ☐ **COMPREHENSIVE METABOLIC PANEL (CMP)** (80053).........Sodium, Potassium, Chloride, CO2, BUN, Glucose, Creatinine, Calcium, Total Protein, Albumin, Total bilirubin, ALK Phos., AST, ALT
- ☐ **BASIC METABOIC PANEL (BMP)** (80048) ....Sodium, Potassium, Chloride, CO2, BUN, Glucose, Creatinine, Calcium
- ☐ **LIVER (HEPATIC) FUNCTION PANEL** (80076).........................Total Protein, Albumin, Direct bilirubin, Total bilirubin, ALK Phos., AST, ALT
- ☐ **LIPID PANEL** (80061)..Cholesterol, HDL, LDL, LDHDL, Triglycerides
- ☐ **RENAL FUNCTION PANEL** (80069)...Sodium, Potassium, Chloride, CO2, Glucose, BUN, Creatinine, Albumin, Phos., Calcium
- ☐ **ELECTROLYTES (LYTES)** (80051) ....Sodium, Potassium, Chloride, CO2

CHEMISTRY

- ☐ Albumin (82040)
- ☐ ALT (SGPT) (84460)
- ☐ AST (SGOT) (84450)
- ☐ Bilirubin, Direct (82248)
- ☐ Bilirubin, Total (82247)
- ☐ BUN (84520)
- ☐ Creatinine 82565
- ☐ Hemoglobin, A1C (83036)
- ☐ Potassium (84132)
- ☐ Magnesium (83735)
- ☐ Phosphorus (84100)
- ☐ TSH (84443)
- ☐ FT4 (84439)*
- ☐ BNP (83880)
- ☐ B12 (82607)
- ☐ C-Reactive Protein (CRP) (86140)
- ☐ CPK (82550)
- ☐ Other ______________________

HEMATOLOGY

- ☐ Protime (INR) (85610)
- ☐ CBC with Differential (85025)
- ☐ CBC(hemogram) (85027)
- ☐ Platelet Count (85049)
- ☐ HH (85014, 85018)
- ☐ Manual Differential, WBC (85004)
- ☐ Sed Rate (ESR) (85652)
- ☐ Other ___________________________

THERAPEUTIC DRUGS

- ☐ Depakote (80164)
- ☐ Tegretol (80156)
- ☐ Vancomycin, Random (80202)
- ☐ Vancomycin, Trough (80202)
- ☐ Lamotritigine (82491)
- ☐ Levetiracetam (80177)
- ☐ Leflunomide (82542)
- ☐ Other _________________________

URINE – INDICATE COLLECTION TYPE

☐ **CLEAN CATCH** ☐ **CATH**

- ☐ Urinalysis, Complete (81001)
- ☐ UA, Reflex to Culture (81001)
- ☐ Urine Culture (87086)
- ☐ Other ________________________________

MISCELLANEOUS TESTS

- ☐ Microalbumin, Random Urine Panel (82043, 82570)
- ☐ Stool Culture (87045, 87046, 87015)
- ☐ Wound Culture (87070, 87205)
  Source:_________________________
- ☐ Other __________________________________

The Pathologists have designated a number of "reflex" tests, which when performed immediately on positive results, expedite patient care and diagnosis. These tests are marked by an asterisk (*). Please refer to the GRMC Laboratory Test Catalog for further information.

OTHER INSTRUCTION:____

____

Phone Results:_________________________ Fax Results to:____________________________

Physician/Provider's Signature:________________________________ Date: ______________

Facility Name______________________

Address___________________________

____

____

Phone_____________________________

Fax_____________________________

WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT, RATHER THAN FOR SCREENING PURPOSES.

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