

LABORATORY OUTPATIENT REQUISITION



CHI Mercy Health
Mercy Medical Center
 2700 Stewart Parkway Roseburg, OR 97471
LABORATORY - (541) 677-2389

Patient Information							
Name (Last, First)				<input type="checkbox"/> Male Date of Birth (Month, Day, Year)		Date:	
Patient / Insured's Address		Apt. #		City		State	Zip
						Telephone Number ()	

Ordering Physician Information							
Physician's Name (To Print on Report)		Ordering Physician's Signature		UPIN #		Call / Fax To (Circle which)	
Duplicate Report To <input type="checkbox"/>		Physician's Name		Address		Number	

PLEASE BILL TO:							
INSURANCE		PATIENT		CLIENT		BILLING INFO ATTACHED	

Medicare will only pay for items and services it determines to be reasonable and necessary under Section 1862 (a) (1) of Medicare law. An Advanced Beneficiary Notice (ABN) must be provided in advance of furnishing non-covered items.								
Diagnosis Codes All That Apply		1	2	3	4	5	6	7

SPECIMEN INFORMATION							
DATE COLLECTED		TIME COLLECTED		MEDICATION		LAST DOSE	
		<input type="checkbox"/> AM <input type="checkbox"/> PM				DATE	
<input type="checkbox"/> Fasting <input type="checkbox"/> Non Fasting		<input type="checkbox"/> Outpatient (Type OP) <input type="checkbox"/> Non Patient (Type REF)		URINE SPECIMEN		COAG THERAPY	
		<input type="checkbox"/> CATH <input type="checkbox"/> CLEAN CATCH <input type="checkbox"/> RANDOM		24 HR URINE VOL		COLLECTED BY	

CHEMISTRY			URINES		PANELS (see back for components)					
<input type="checkbox"/> AFP <input type="checkbox"/> Albumin <input type="checkbox"/> Alk phos <input type="checkbox"/> ALT (SGPT) <input type="checkbox"/> Amylase <input type="checkbox"/> ANA <input type="checkbox"/> AST (SGOT) <input type="checkbox"/> B12 <input type="checkbox"/> Bilirubin, Total <input type="checkbox"/> Bilirubin, Direct <input type="checkbox"/> BUN <input type="checkbox"/> CRP (C-reactive protein) <input type="checkbox"/> hs-CRP <input type="checkbox"/> CA-125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CA 15-3 <input type="checkbox"/> Calcium <input type="checkbox"/> CEA <input type="checkbox"/> Chloride <input type="checkbox"/> Cholesterol <input type="checkbox"/> CK <input type="checkbox"/> CK with CKMB if indicated <input type="checkbox"/> CKMB <input type="checkbox"/> Cortisol AM ____ PM ____ <input type="checkbox"/> Creatinine <input type="checkbox"/> Depakane <input type="checkbox"/> Digoxin			<input type="checkbox"/> Dilantin <input type="checkbox"/> Estradiol <input type="checkbox"/> Ferritin <input type="checkbox"/> Folic Acid <input type="checkbox"/> FSH <input type="checkbox"/> Gestational Screen <input type="checkbox"/> Gestational GTT <input type="checkbox"/> Glucose <input type="checkbox"/> Glyco Hgb <input type="checkbox"/> HBsAb <input type="checkbox"/> HCG quant. (serum) <input type="checkbox"/> Hepatitis A ab Total <input type="checkbox"/> Hepatitis C ab <input type="checkbox"/> HIV Antibody <input type="checkbox"/> IgA, IgG, IgM <input type="checkbox"/> IgE <input type="checkbox"/> SPEP <input type="checkbox"/> Iron <input type="checkbox"/> Iron/IBC <input type="checkbox"/> Lactic Acid <input type="checkbox"/> LDH <input type="checkbox"/> LH <input type="checkbox"/> Lipase <input type="checkbox"/> Lithium <input type="checkbox"/> Magnesium <input type="checkbox"/> Mono test <input type="checkbox"/> MSAFP		<input type="checkbox"/> Phenobarbital <input type="checkbox"/> Phos. <input type="checkbox"/> Potassium <input type="checkbox"/> Pregnancy, qual. <input type="checkbox"/> Urine <input type="checkbox"/> Serum <input type="checkbox"/> Protein, total <input type="checkbox"/> PSA Screening Available every 12 months, use code V76.44 <input type="checkbox"/> PSA Diagnostic <input type="checkbox"/> RA <input type="checkbox"/> Screen Only <input type="checkbox"/> Screen w/if elevated <input type="checkbox"/> RPR (VDRL) <input type="checkbox"/> Rubella <input type="checkbox"/> Sodium <input type="checkbox"/> T3 u <input type="checkbox"/> T4 <input type="checkbox"/> T4 free <input type="checkbox"/> Tegretol <input type="checkbox"/> Theophylline <input type="checkbox"/> Toxoplasma IgG <input type="checkbox"/> Toxoplasma IgM <input type="checkbox"/> Transferrin <input type="checkbox"/> Triglycerides <input type="checkbox"/> TSH <input type="checkbox"/> Uric acid <input type="checkbox"/> Urine Toxi Screen <input type="checkbox"/> Creatinine clear. (Requires timed urine and serum)		<input type="checkbox"/> STAT <input type="checkbox"/> ASAP URINALYSIS <input type="checkbox"/> Microscopic if Indicated <input type="checkbox"/> Microscopic if Ind. & Cult. If Ind. <input type="checkbox"/> With Microscopic <input type="checkbox"/> W/Microscopic/Culture if Ind. HEMATOLOGY/BB <input type="checkbox"/> Occult Blood - Screening <input type="checkbox"/> Occult Blood - Diagnostic <input type="checkbox"/> Hematocrit 85014 <input type="checkbox"/> Hemoglobin 85018 <input type="checkbox"/> CBC w/o dif (Hemogram) 85027 <input type="checkbox"/> CBC w/ + Auto dif 85025 <input type="checkbox"/> CBC w/ Manual dif 85027 & 85007 <input type="checkbox"/> Body fluid cell CT & diff <input type="checkbox"/> Platelet count <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> Fibrinogen <input type="checkbox"/> Retic count <input type="checkbox"/> Sed rate <input type="checkbox"/> Type & Rh <input type="checkbox"/> Coombs <input type="checkbox"/> Crossmatch _____ # units		<input type="checkbox"/> Basic metabolic <input type="checkbox"/> Comprehensive metabolic <input type="checkbox"/> Electrolytes <input type="checkbox"/> Liver <input type="checkbox"/> Hep. Acute ABC <input type="checkbox"/> Lipid <input type="checkbox"/> Obstetric <input type="checkbox"/> Renal Function Panel MICROBIOLOGY <input type="checkbox"/> SOURCE _____ <input type="checkbox"/> Routine culture (Gram stain, ID & susceptibility performed if ind. at an additional charge) <input type="checkbox"/> Anaerobic Culture <input type="checkbox"/> Genital culture Routine <input type="checkbox"/> Genital culture (Grp B Strep only) <input type="checkbox"/> AFB (TB) culture & smear <input type="checkbox"/> Fungus culture <input type="checkbox"/> Gram stain <input type="checkbox"/> Urine Culture (ID/susceptibility performed if indicated at an additional charge) <input type="checkbox"/> Chlamydia/GC Probe <input type="checkbox"/> C. Difficile <input type="checkbox"/> Herpes Culture <input type="checkbox"/> KOH Prep <input type="checkbox"/> Persistent Diarrhea Panel <input type="checkbox"/> Other _____	

Additional Tests / Notes: