

Fort HealthCare Lab 611 E. Sherman Ave. Fort Atkinson, WI 53538 920-568-5250 Fax 920-568-5003		Patient Identification (Name)
Medicare HOSPICE election made? YES <input type="checkbox"/> NO <input type="checkbox"/>		

ORDERING PHYSICIAN		and/or FACILITY	
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DATE OF BIRTH	SEX	DATE AND TIME DRAWN	FASTING? YES <input type="checkbox"/> NO <input type="checkbox"/>	MDCR PART A OR PART B? A <input type="checkbox"/> B <input type="checkbox"/>
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Medicare/Medicaid Additional Information		Insurance Billing Additional Information	
Medicare/Medicaid No.	HOSPICE name, if applicable	Patient Address	
Patient Address		City	State Zip
City	State Zip	Phone No.	Marital Statue
Phone No.		Responsible Party Name	Relationship
Supplemental Insurance		Responsible Party's Employer	Insurance Company
ICD-10 Codes:		Policy No.	Group No.

NOTE: When ordering tests for which Medicare reimbursement will be sought, tests should only be ordered that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. If screening tests are ordered, obtain a signed Advanced Beneficiary Notice from the patient, as such screening test are not covered by Medicare.

For Clinical Consultation in test ordering, contact Dr. Turski at 920-568-5252.

Specimen requirement code follows ICD-10 field. See chart below (bottom right) for specimen tube codes.

Test	Dx or ICD-10	Test	Dx or ICD-10
<input type="checkbox"/> Basic metabolic panel	_____ G	<input type="checkbox"/> Hepatic Function	_____ G
<input type="checkbox"/> B-N Peptide	_____ L	<input type="checkbox"/> Iron	_____ G
<input type="checkbox"/> Carbamazepine/Tegretol	_____ G	<input type="checkbox"/> K (Potassium)	_____ G
<input type="checkbox"/> CBC c Man. Diff if Indicated @	_____ L	<input type="checkbox"/> Lipid Panel	_____ G
<input type="checkbox"/> Comprehensive Metabolic Panel	_____ G	<input type="checkbox"/> Lithium	_____ R
<input type="checkbox"/> Creatinine	_____ G	<input type="checkbox"/> Phenytoin/Dilantin	_____ SST
<input type="checkbox"/> Culture Urine source: _____ @*	_____ U	<input type="checkbox"/> Protine	_____ B
<input type="checkbox"/> Culture wound source _____ @*	_____	<input type="checkbox"/> PSA	_____ SST
<input type="checkbox"/> Stool Pathogen Screen (PCR)	_____ S	<input type="checkbox"/> Sed Rate	_____ L
<input type="checkbox"/> Digoxin	_____ G	<input type="checkbox"/> T4 Free	_____ G
<input type="checkbox"/> Electrolyte Panel	_____ G	<input type="checkbox"/> TSH	_____ G
<input type="checkbox"/> Folate	_____ SST	<input type="checkbox"/> UA micro if indicated**	_____ U
<input type="checkbox"/> Glucose	_____ G	source: _____	_____
<input type="checkbox"/> HDL	_____ G	<input type="checkbox"/> UA culture if indicated*	_____ U
<input type="checkbox"/> Hematology Profile/Hemogram	_____ L	source: _____	_____
<input type="checkbox"/> Hgb A1C	_____ L	<input type="checkbox"/> Valproate/Depakote	_____ G
<input type="checkbox"/> Hgb <input type="checkbox"/> Hct	_____ L	<input type="checkbox"/> Vitamin B12	_____ SST

@CBC with manual diff performed if indicated per measured abnormalities/failures.

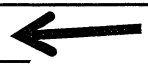
@\*Sensitivity testing done on all pathogens isolated

\*\* Indications for microscopic: nitrate, leukocyte, protein or blood positive

\* Indications for culture: >5 WBC with less than 3+ Squamous Epithelials

R	= Red Top Tube
G	= Green Top Tube
L	= Lavender Top Tube
B	= Light Blue Top Tube
U	= Screw top urine container
S	= Special Collection - Call Lab
SST	= Yellow Top Tube

Other Testing:



Signature of Ordering Physician, or Person Completing This Form