Fort HealthCare Lab
611 E. Sherman Ave.
Fort Atkinson, WI 53538
920-568-5250
Fax 920-568-5003

Fort HealthCare
For Health

Medicare **HOSPICE** election made?
YES ☐ NO ☐

Patient Identification (Name)

ORDERING PHYSICIAN and/or FACILITY

DATE OF BIRTH	SEX	DATE AND TIME DRAWN	FASTING? YES ☐ NO ☐	MDCR PART A OR PART B? A ☐ B ☐

Medicare/Medicaid Additional Information

Medicare/Medicaid No.	HOSPICE name, if applicable

Patient Address

City State Zip

Phone No.

Supplemental Insurance

ICD-10 Codes:

Insurance Billing Additional Information

Patient Address

City State Zip

Phone No.	Marital Statue

Responsible Party Name	Relationship

Responsible Party's Employer	Insurance Company

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	
☐	Basic metabolic panel	_____	G
☐	B-N Peptide	_____	L
☐	Carbamazepine/Tegretol	_____	G
☐	CBC c Man. Diff if Indicated @	_____	L
☐	Comprehensive Metabolic Panel	_____	G
☐	Creatinine	_____	G
☐	Culture Urine source: _____@*	_____	U
☐	Culture wound source _____@*	_____	
☐	Stool Pathogen Screen (PCR)	_____	S
☐	Digoxin	_____	G
☐	Electrolyte Panel	_____	G
☐	Folate	_____	SST
☐	Glucose	_____	G
☐	HDL	_____	G
☐	Hematology Profile/Hemogram	_____	L
☐	Hgb A1C	_____	L
☐	Hgb ☐ Hct	_____	L

	Test	Dx or ICD-10	
☐	Hepatic Function	_____	G
☐	Iron	_____	G
☐	K (Potassium)	_____	G
☐	Lipid Panel	_____	G
☐	Lithium	_____	R
☐	Phenytoin/Dilantin	_____	SST
☐	Protime	_____	B
☐	PSA	_____	SST
☐	Sed Rate	_____	L
☐	T4 Free	_____	G
☐	TSH	_____	G
☐	UA micro if indicated**	_____	U
☐	source:_____		
☐	UA culture if indicated*	_____	U
☐	source:_____		
☐	Valproate/Depakote	_____	G
☐	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

Other Testing:

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

Signature of Ordering Physician, **or Person Completing This Form**

LAB-61 Mar 27 2017