

CLINICAL TEST REQUEST FORM

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME		FIRST NAME		MI	STAT <input type="checkbox"/>	COLLECTION DATE		TIME	REPORT	
DOB / /		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PT. ID# / ADDITIONAL INFO		/ /		AM/PM	<input type="checkbox"/> CALL <input type="checkbox"/> FAX	
SSN		BILL <input type="checkbox"/> OFFICE/CLIENT <input type="checkbox"/> PATIENT INSURANCE		PROVIDER: _____ (Last, First, MI)		Account Number _____		Account Name _____		
PATIENT INSURANCE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)					Street Address _____		City _____ State _____ Zip Code _____		Phone Number _____ Fax Number _____	
ADDRESS		CITY		STATE	ZIP		EFFECTIVE DATE / / DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)			
PRIMARY INSURANCE <input type="checkbox"/> MEDICARE IN-PATIENT <input type="checkbox"/> MEDICARE OUT-PATIENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE		POLICY ID#		GROUP ID#		ICD-10 #1 ICD-10 #2 ICD-10 #3				
INSURANCE COMPANY		PHONE NUMBER		SECONDARY / TERTIARY INS - ATTACH INFORMATION						
INSURANCE COMPANY ADDRESS		CITY		STATE	ZIP		NOTICE: 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. FOR MORE INFORMATION SEE reglab.org/billingcompliance/			
ICD-10 #1 ICD-10 #2 ICD-10 #3					<input type="checkbox"/> ABN ATTACHED <input type="checkbox"/> PRIOR AUTHORIZATION ATTACHED					

EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER

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1	2	3	PANELS (see components on back of form)	1	2	3	INDIVIDUAL TESTS	1	2	3	INDIVIDUAL TESTS	1	2	3	**MICROBIOLOGY/VIROLOGY
			BASIC METABOLIC LG				CEA S				POTASSIUM LG				AFB CULTURE*: _____ source
			ELECTROLYTES LG				CHOLESTEROL LG				PROLACTIN LG				AEROBIC CULTURE: _____ source
			COMPREHENSIVE METABOLIC LG				CHRONIC HEART FAILURE PEPTIDE (CHFP) L				PROTEIN ELECTROPHORESIS, SERUM S				ANAEROBIC CULTURE: _____ source
			LIPID LG				CK <input type="checkbox"/> CKMB LG				PROTEIN, TOTAL LG				BLOOD CULTURE: <input type="checkbox"/> ADULT (BLDCU) <input type="checkbox"/> PEDIATRIC (BLDA) source: _____
			HEPATIC LIVER FUNCTION S				CREATININE LG				PROTIME _____ Anticoagulant LB				BORDETELLA PERTUSSIS CULTURE: _____ source
			OBSTETRIC (OB PNL) S, L				CORTISOL ____ 8 AM ____ 4 PM LG				PTT _____ Anticoagulant LB				C. DIFFICILE TOXIN* (Stool)
			HEPATITIS PANEL, ACUTE S				ESTRADIOL LG				PSA <input type="checkbox"/> SCREEN <input type="checkbox"/> DIAGNOSTIC S				FUNGAL CULTURE: _____ source
			CELIAC DISEASE SCREEN S				FERRITIN LG				PROGESTERONE S				FUNGAL-DERMATOPHYTE CULTURE: _____ source
			ALLERGY PANEL IgE PEDS MARCH S				FOLIC ACID (Folate, Serum) LG				RETICULOCYTE COUNT L				GC/CHLAMYDIA PROBE: _____ source
			ALLERGY PANEL IgE REGION 9 S				FSH LG				RHEUMATOID FACTOR S				GASTROINTESTINAL PATHOGEN PANEL (GIP)
			ALLERGY PANEL IgE FOOD ALLERGENS S				HCG QUALITATIVE (Pregnancy Test) S				RUBELLA, IgG S				HELICOBACTER PYLORI ANTIGEN* (Stool)
			INDIVIDUAL TESTS				HCG QUANTITATIVE S				SED RATE (ESR) L				OVA & PARASITE: <input type="checkbox"/> Foreign Travel (OVPAR) <input type="checkbox"/> No Travel (OVPCY)
			A-FETOPROTEIN TUMOR MKR S				GAMMA GT LG				SYPHILIS IgG SCREEN S				SPUTUM CULTURE*
			ALT LG				GLUCOSE ____ Fasting ____ Non Fasting LG				T4 (Free) S				RAPID GROUP A STREP SCREEN (Throat)
			AMYLASE LG				HEMOGLOBIN A1C (Glycolated Hgb) L				TB INTERFERON SPECIAL				RESPIRATORY PATHOGEN PNL BY PCR* (RESPP)
			ANA IFA w reflex to titer and ANAPN (ANAFLX) S				HEMOGLOBIN & HEMATOCRIT L				TESTOSTERONE (TST), TOTAL S				STREP GROUP A CULTURE (Throat)
			ANA Screen with reflex to ANAPN (ANASCR) S				HEPATITIS A Ab(IgM) S				TST PANEL - Males (SHBG, tTST, fTST, %fTST): TSFTST S				TISSUE CULTURE*: _____ source
			ANA IFA with titer (ANAIF) S				HEPATITIS B CORE Ab (Total) IgG, IgM S				TST PANEL - Female & Children: TESTOS S				GROUP B STREP CULTURE*: _____ source
			ABO/RH/ANTIBODY SCREEN L				HEPATITIS B SURFACE Ab (HBsAb) S				TROPONIN I LG				URINE CULTURE*: _____ source
			AST LG				HEPATITIS B SURFACE Ag (HBsAg) S				TSH, Ultra Sensitive LG				VAGINAL PATHOGENS DIRECT PROBE (Trichomonas, Candida, Gardnerella)
			BILIRUBIN <input type="checkbox"/> TOT <input type="checkbox"/> DIR LG				HEPATITIS C Ab S				URIC ACID LG				MOLECULAR VIROLOGY
			BUN LG				HEPATITIS C Ab with reflex to Hep C RNA Quant S				URINALYSIS (Dispstick, microscopic if indicated) U				Provide source for testing below
			C-REACTIVE PROTEIN (CRP) HIGH Sens LG				HEPATITIS PANEL, ACUTE S				URINALYSIS (Dipstick + microscopic) U				ADENOVIRUS DNA DETECTION
			C-REACTIVE PROTEIN (CRP) LG				HEPATITIS PANEL, ACUTE with reflex to Hep C RNA Quant S				VITAMIN B12 LG				CMV DNA DETECTION
			CALCIUM LG				HERPES SIMPLEX VIRUS 1 AND 2 S				VITAMIN D 25 OH S				ENTEROVIRUS RNA DETECTION
			CA 125 S				HIV Panel (HIV-1 p24, HIV-1 Ab, HIV-2 Ab) S				WEST NILE IgG, M <input type="checkbox"/> SERUM <input type="checkbox"/> CSF S				HERPES VIRUS PNL - MULTIPLEX (CMV,HSV,EBV,VZV,HHV-6)
			CA 15-3 S				IRON <input type="checkbox"/> TIBC (inc: Transferrin) LG				TIMED URINE TEST				HSV 1 & 2 DNA DETECTION AND GENOTYPE
			CA 19-9 S				LD LG				TEST NAME _____				HSV DNA DIRECT DETECTION
			CBC (Autodiff, plt ct) (CBCP) L				LIPASE LG				____ Hrs. Collected _____ Total Volume				VARICELLA ZOSTER VIRUS DNA DETECTION
			CBC w/o Diff (HEMOGRAM) (SCTP) L				MAGNESIUM LG				DRUG LEVELS				
							MICRO ALBUMIN, URINE ____ Random ____ 24hr U				DRUG _____ R				
							MONOSPOT S				PRE ____ POST ____ RANDOM				
							PHOSPHORUS LG								

ADDITIONAL TEST INFO/COMMENTS

FOR DETAILED TESTING INFORMATION VISIT REGLAB.ORG



Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/ testing supplies and log-on information may be obtained by calling Client Services
Toll Free 800-334-0459
Phone 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call
client services Toll Free 800-334-0459
Phone 402-559-6420

If shipping specimens address to:
UNMC Shipping & Receiving Dock
Regional Pathology Services MSB 3500
University of Nebraska Medical Center
601 Saddle Creek Road
Omaha, NE 68106-1180

Transport Instructions:

Specimen Handling/Shipping

To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?

Contact client services at 800-334-0459