University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha, Nebraska 68198-1180
www.reglab.org

Toll Free: 1.800.334.0459
Phone: 402.559.6420
FAX: 402.559.9497

Platelet Electron Microscopy Test Request Form

RPS Use Only

Accession #: _____

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME | FIRST NAME | MI

DOB / / | GENDER ☐ MALE ☐ FEMALE | PT. ID# / ADDITIONAL INFO

SSN - - | BILL ☐ OFFICE/CLIENT ☐ PATIENT INSURANCE

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)

ADDRESS | CITY | STATE | ZIP

PRIMARY INSURANCE
☐ **MEDICARE IN-PATIENT** ☐ **MEDICARE OUT-PATIENT** ☐ **MEDICAID** ☐ **INSURANCE**

POLICY ID# | **GROUP ID#**

INSURANCE COMPANY | PHONE NUMBER

INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP

EFFECTIVE DATE / /

DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)

ICD-10 #1 | ICD-10 #2 | ICD-10 #3

Collection Date _____/_____/_____ **Collection Time** _____ **AM PM**

PROVIDER: _____
(First, Last, MI)

SECONDARY / TERTIARY INS – ATTACH INFORMATION

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/**

☐ ABN ATTACHED
☐ PRIOR AUTHORIZATION ATTACHED

NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis. If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. ☐ **Check the box if additional reference laboratory testing is not desired.** Please note that a definitive diagnosis may not be possible.

EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER | **EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER**

Platelet Electron Microscopy Test Request Form
(Specimen Collection/Submission protocol – see back of form)

BLEEDING HISTORY & MEDICAL HISTORY

	Bleeding History-Check all that apply		Other Symptoms-Check all that apply
	Easy Bruising		IBS
	Bruising related to menstrual cycle		Depression
	Bruising worsened by ASA or NSAIDs		ADD/ADHD
	Heavy menstrual bleeding		Autoimmune Disease
	Dental/Bleeding gums		Hyperflexibilty
	Epistaxis		Chronic Infection
	No bleeding History		Other:

POST-OPERATIVE BLEEDING HISTORY

Procedure	Details

FAMILY BLEEDING HISTORY

Should include mother, father, siblings, children, maternal relatives, paternal relatives if relevant

Family Member	Details

Laboratory Results

PT		PFA	
NE		HGB	
LY		RDW	
MO		MCV	
EO		MPV	
aPTT		vWF Activity	
RBC		vWF Antigen	
WBC		VII Activity	
HCT		BA	
PLT#			

Platelet Aggregation Studies (RIST, COL, EPI, ADP)

Circle One: Normal Abnormal Not Done

Bleeding Checklist Score: _____

Method: _____

Pathologists Contact Information
Dr. Kirk Foster 1-402-559-8412 or Dr. Geoffrey Talmon 1-402-559-4793

FOR DETAILED TESTING INFORMATION VISIT REGLAB.ORG

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