UT Southwestern Medical Center

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6201 Harry Hines Blvd.
Dallas, Texas 75390
Phone : 214-645-1490 • Fax : 214-645-1471

LABORATORY SERVICES TEST REQUEST FORM

LAST NAME | FIRST NAME | MIDDLE INITIAL

RESPONSIBLE PARTY NAME (If other than pt) _____

ADDRESS _____ SS # _____ - _____ - _____

CITY _____ SEX M F D.O.B. _____

STATE _____ ZIP _____ PHONE ( ) _____ CHART # _____

SPECIMEN COLLECTED DATE _____ REFERRING PHYSICIAN

❑ Fasting ❑ Non-fasting

TIME _____ ❑ AM ❑ PM COLLECTED BY _____ V

❑ PATIENT SELECTED LAB _____ EMPLOYEE INITIALS

❑ STAT ❑ ROUTINE CALL _____ FAX _____

❑ Do NOT call MD with abnormals after office hours _____

NOTICE: Bills will be submitted for payment to Medicare, Medicaid, all other governmental programs, and third party payors based upon the diagnostic information provided by the treating physician.

INFORMATION RELEASE/ASSIGNMENTS AUTHORIZATION:
— I authorize the release of any medical information necessary to process a claim.
— I request payment to provider of any medical insurance benefits.

Signature: _____ Date: _____

❑ MEDICARE Each test ordered must be checked/ordered individually. Diagnosis/ABN required under section 1862(a)(1) of the Medicare law.

BILL TO: ❑ PATIENT ❑ INSURANCE ❑ HMO/IPA ❑ MEDICAID ❑ WKR. COMP

INSURANCE COMPANY _____ POLICY # _____

ADDRESS _____ GROUP # _____

CITY _____ STATE _____ ZIP _____

PHONE NO. _____

SUBSCRIBER'S NAME _____ SS NO. _____

MEDICARE # _____ RELATIONSHIP _____

EMPLOYER _____

ADDRESS _____ PHONE# _____

DATE OF INJURY IF WORKERS COMP _____ CLAIM # _____

Adjustor's name _____ Adjustor's Tel. # _____

General instruction for Governmental Payers. All orders for Clinical laboratory tests must include a statement of the medical reason for those tests. The reason(s) listed below must be linked with the test(s) ordered by noting the number of the reason in the space next to the test ordered. If a specific test is not supported by documentation in the medical record or is clearly for screening purposes, the test must be designated as a "Screening Test" and must be accompanied by the signed ABN.

DIAGNOSIS-SYMPTOMS and ICD-10 (CODES) _____

Screening Test: All tests ordered for the purpose of screening, including tests ordered as part of routine physical examinations, must be accompanied by an ABN completed by the ordering physician and signed by the patient. Laboratories may not bill the patient for the service unless the ABN has been completed and signed by the patient prior to the rendition of the service(s). **ABN/MSP**

X PLEASE CHECK BOX

PANELS

❑	**ELECTROLYTES PANEL 80051** Na, K, Cl, CO2	LI/S
❑	**BASIC METABOLIC PANEL 80048** Na, K, Cl, CO2, Glu, BUN, Creat, Ca,	LI/S
❑	**RENAL FUNCTION 80069** Na, K, Cl, CO2, Glu, BUN, Creat, Alb, Ca, PO4	LI/S
❑	**COMPREHENSIVE METABOLIC PANEL 80053 (CMP)** Na, K, Cl, CO2, Glu, BUN, Creat, T.P., Alb, Ca, T.B., Alk Phos, ALT, AST	LI/S
❑	**OBSTETRIC PANEL 80055** CBCDIFF, HBsAg*, Rubella Ab, RPR*, Ab Screen*, ABO & RH	R/S/L
❑	**LIVER FUNCTION 80076** T.Protein, Alb, T&D Bili, Alk Phos, ALT, AST	LI/S
❑	**ACUTE HEPATITIS PANEL 80074** Hepatitis A Ab (HAAb) IgM, Hepatitis B core Ab (HBcAb) IgM, Hepatitis B Surface Ag (HBsAg)*, Hepatitis C Ab	S
❑	**LIPID PANEL 80061** Chol, Trig, HDL, includes Risk Ratio	LI/S

INDIVIDUAL TESTS

❑	Complete Blood Count Auto Diff & Plt* **85025** ❑	L
❑	Hemogram/Platelet* **85027** ❑	L
❑	Partial Thromboplastin Time **85730**	B
❑	Prothrombin Time **85610**	B
❑	Sed Rate **85651**	L
❑	Urinalysis w/Microscopy **81001**	U
❑	Urinalysis w/reflex to microscopy* **81003** ❑	U

TRANSFUSION SERVICES

- ❑ Ab Screen 86850
- ❑ ABO & Rh* (86900/86901) ❑
- ❑ ABO* (86900) ❑
- ❑ Rh* (86901) ❑

MICROBIOLOGY

❑ Source: _____

- ❑ Urine C/S* ❑
- ❑ Stool C/S* ❑
- ❑ Aerobic C/S* ❑
- ❑ Anaerobic Culture* ❑
- ❑ AFB Culture* ❑
- ❑ Ova & Parasites* ❑
- ❑ Fungal Culture* ❑

*These tests may be reflexed based on test result; select ❑ if reflex not required.

*See back for complete listing of reflex test. For reflex criteria refer to UTSW laboratory manual or Annual Notice to Physicians.

CHEMISTRY

❑	ANA*	86038	
❑	Alb	82040	
❑	Alk Phos	84075	
❑	ALT	84460	
❑	AST	84450	
❑	D.Bili	82248	
❑	BUN	84520	
❑	Ca	82310	
❑	Chol	82465	
❑	CK	82550	
❑	Cl	82435	
❑	CO_2	82374	
❑	Creat	82565	
❑	Free T4*	❑ 84439	
❑	GGTP	82977	
❑	Gluc	82947	
❑	HAAb IgM	86709	
❑	HBcAb IgM	86705	
❑	HBsAg*	❑ 87340	
❑	Hemoglobin A1C	83036	
❑	HepCAb	86803	
❑	HIV AG/AB Screen*	❑87389	
❑	K	84132	
❑	LDH	83615	
❑	Mg	83735	
❑	Na	84295	
❑	Phos	84100	
❑	PSA ❑Screen	84153	
❑	RA Factor	86431	
❑	RPR* ❑	86592	
❑	Rubella	86762	
❑	T.Bili	82247	
❑	T.Protein	84155	
❑	Trig	84478	
❑	TSH*	❑ 84443	
❑	T3 UPTAKE	84479	
❑	Uric Acid	84550	

PHYSICIAN ACKNOWLEDGMENT AND CERTIFICATION:

The physician certifies for the Hospital/Laboratory that either: 1. The tests ordered are medically necessary and specific tests ordered on this requisition are necessary for the diagnosis and treatment of the patient; the physician is treating the patient in connection with the diagnosis or complaints listed on this requisition; the information on this requisition accurately reflects the medical reasons for requesting the specific tests ordered on this requisition, and the medical necessity of each of the individual tests ordered on this requisition is appropriately documented in the patient's medical record; or, 2. The tests ordered are for purposes of screening that the physician believes is appropriate for the patient even though the payor may not allow reimbursement for the tests; and the fact that payment is likely to be denied by Medicare or other payors has been explained to the patient, who has agreed to pay for the tests personally by signing the attached Advance Beneficiary Notice (ABN).

X _____ Date _____ Time _____

Authorized Signature Required (submitting physician or designee) Failure to do so will result in a delay of testing.

LAB USE ONLY BELOW THIS LINE - INDICATE NUMBER OF SPECIMENS RECEIVED IN LAB

L	B	G	S	LI	GR	GRY	P	FS	U	PAP	Swab	Other

L-Lavender B-Blue G-Gold S-SST/Serum LI-Lithium GR-Green GRY-Gray P-Plnk FS-Frozen Serum U-Urine

Reflex Tests:

Abnormal Amniotic Fluid AFP ref to acetylcholinesterase; + Adsorption reflexes to RBC Antibody ID; AFB Smear added to AFB culture; + Amphetamine Screen ref to Drug Confirmation; Gram stain provided with Anaerobic Cultures; + ANA ref to ANA titers; + DsDNA ref to DsDNA titer; Special Stains ordered by pathologist as ref to Anatomic Pathology Specimens; + AB Elution ref to RBC AB ID; + AB Screen or IAT ref to Identification plus Titers, DAT, Adsorption, Cold Agglutinin Screen if necessary; + Antiphospholipid Syndrome ref to DVVT, Silica Clotting Confirm Time, Coag/Fibrinolysis Test Interpretation; Abnormal ABO & RH ref to second determination of blood type and/or addt'l Typing or AB ID; Cytochem stains performed after bone marrow analysis; Abnormal CBC w diff ref to pathologist review; Gram stain added to CSF culture; Abnormal Cold Agglutinin ref to titer; Abnormal Coagulation Factor Inhibitor Screen ref to Quant ; Incompatible crossmatch ref to AB ID; + Cryptococcal Ag ref to titer; Abnormal cultures ref to Org IDs and Susceptibility Testing; + DAT ref to anti-IgG & anti-C3 and possibly AB elution; +FMH ref to K-B Test; FNA ref to Thyroglobulin FNA Lymph Node; HBsAg ref to HBsAg Neutralization; + HBcAB ref to HBcAB IgM; +HCV AB ref to HCV RNA; + HIT AB ref to SRA; + HIV AG/AB ref to HIV 1 & HIV 2 Diff Geenious Test; + HLA AB Screen ref to HLA Ab Single Antigen; Lipid Panel ref to LDL Direct if Trig > 400 and <1000; Additional Chromosome Analysis and Fluorescence In-Situ Hybridization performed with Microarray; Normal FISH ref to MYC Break Apart probe FISH; Neg Opiate Screen ref to Oxycodone Screen; + Opiate Screen ref to Opiate confirm; O & P requires inclusion of a trichrome stain and acid fast stains if required; PEP Urine/Serum ref to IFE Urine/Serum; Protein S Antigen (Free and Total) ref to Protein S Functional Assay; Sickle Cell Screening ref to Sickle Cell Confirmation; Stool culture includes screen for Salmonella, Shigella, and Campylobacter with Susceptibility and Shiga Toxin added as needed; Strep Group A antigen ref to Throat Culture; RPR screen ref to RPR Titer and/or TP-PA; Abnormal Thin Prep ref to HPV Testing; + Thyroglobulin AB ref to Thyroglobulin Quantitation by Mass Spectrometry; Thyroid FNA ref to Afirma Testing; Abnormal TSH ref to FT4; Abnormal FT4 ref to FT3; Abnormal UA ref to UA with micro; Atypical Urine Cytology ref to Urovysion Testing; If Viral Serology Testing are indeterminate will require further testing of same testing by a different method