



Outpatient Diagnostic Lab Request Form

PROVIDENCE

HOSPITAL

1150 Varnum Street, N.E. Washington, DC 20017

On arrival, report to outpatient registration on the ground floor

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

| | |
|---------------------------------------|--|
| Collection Date [][][][][][] | Time <input type="checkbox"/> AM <input type="checkbox"/> PM |
|---------------------------------------|--|

| | |
|---|-------------------|
| Type of Specimen <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other | Drawn By _____ |
|---|-------------------|

PANELS

| | |
|--|--|
| <input type="checkbox"/> ARTHRITIS PANEL (Uric acid, Sed-rate, ANA, RA) RAGR SST, P DIAGNOSIS CODE | <input type="checkbox"/> ELECTROLYTE PANEL (Na, K, Cl, CO2) LYTE SST DIAGNOSIS CODE |
| <input type="checkbox"/> BASIC METABOLIC PANEL (Na, K, Cl, CO2, Glu, Bun, Crea) CH7 SST DIAGNOSIS CODE | <input type="checkbox"/> HEPATIC PANEL (Bili, Total & Direct, Alb, ALKP, AST, ALT) HFP SST DIAGNOSIS CODE |
| <input type="checkbox"/> COMPREHENSIVE METAB. PANEL (Alb, T Bili, BUN, Glu, Ca, Crea, ALKP, TP, AST, Lyte) CMP SST DIAGNOSIS CODE | <input type="checkbox"/> LIPID PANEL (Total Chol, Trig, HDL) LIP4 SST DIAGNOSIS CODE |

| HEMATOLOGY & COAG. | CHEMISTRY | MICROBIOLOGY (Indicate Specific Source) | OTHER |
|--|---|--|---|
| <input type="checkbox"/> CBC (Includes platelets) ACBC P | <input type="checkbox"/> AMYLASE AMY SST | <input type="checkbox"/> URINE CULTURE CULU SOURCE: [] | <input type="checkbox"/> TRICYCLICS TCYC R |
| <input type="checkbox"/> HGB/HCT (H/H) HH P | <input type="checkbox"/> BILIRUBIN (Dir&Indir) ABIL SST | | <input type="checkbox"/> DIGOXIN DIG SST |
| <input type="checkbox"/> PLATELET COUNT PLCT P | <input type="checkbox"/> CALCIUM CA SST | | <input type="checkbox"/> LITHIUM LI SST |
| <input type="checkbox"/> RETIC. COUNT RETC P | <input type="checkbox"/> CEA CLA P, FROZ | <input type="checkbox"/> STOOL CULTURE CULS | <input type="checkbox"/> PHENOBARBITAL PHEN SST |
| <input type="checkbox"/> SICKLE CELL PREP SCP P | <input type="checkbox"/> CREATININE CREA SST | <input type="checkbox"/> OVA AND PARASITES OVPA | <input type="checkbox"/> QUINIDINE QUIN SST |
| <input type="checkbox"/> PT PT B | <input type="checkbox"/> CORTISOL _ AM _ PM SST | <input type="checkbox"/> THROAT CULTURE CULT | <input type="checkbox"/> SALICYLATE SALI SST |
| <input type="checkbox"/> PTT PTT B | <input type="checkbox"/> FERRITIN FERN SST | <input type="checkbox"/> GENITAL CULTURE CULG | <input type="checkbox"/> THEOPHYLLINE THEO SST |
| <input type="checkbox"/> BLEEDING TIME TBLX Initials _____ TIME: []: [] Minutes | <input type="checkbox"/> FOLIC ACID & VIT. B12 FOL, VB12 SST | <input type="checkbox"/> ACID FAST CULTURE CAFB SOURCE: [] | <input type="checkbox"/> VALPROIC ACID VALA SST |
| <input type="checkbox"/> URINALYSIS UROM U | <input type="checkbox"/> GLUCOSE _ FBS _ 2HPP GRY GLU, CCOM, PMSG | | <input type="checkbox"/> HEPATITIS BS AG HBSA SST |
| <input type="checkbox"/> URINE PREGNANCY TEST PREG U | <input type="checkbox"/> GLUCOSE TOLERANCE I-PGLU, 3-3GTT, 4-4GTT HR | | <input type="checkbox"/> HEPATITIS BS AB HBAB SST |
| | <input type="checkbox"/> GLYCOHEMOGLOBIN HBIC P | <input type="checkbox"/> FUNGUS CULTURE CFUN SOURCE: [] | <input type="checkbox"/> HEPATITIS A AB, 1gQ/ 1gM HAVG SST |
| | <input type="checkbox"/> HIV HIV 1 SST | | <input type="checkbox"/> HEPATITIS A AB, 1gM HAVM SST |
| | <input type="checkbox"/> HCG BETA SUBUNIT, QUAL. BHCG SST | | <input type="checkbox"/> HEPATITIS B CORE AG HBCA SST |
| | <input type="checkbox"/> HCG, QUANTITATIVE HCGQ. SST | | <input type="checkbox"/> HEPATITIS C HCV SST |
| | <input type="checkbox"/> IRON/TIBC IRON, TIBC SST | <input type="checkbox"/> VIRAL CULTURE CVIR TYPE (Specify): [] SOURCE: [] | <input type="checkbox"/> BLOOD BORNE PATHOGEN EXPOSURE <input type="checkbox"/> SOURCE HBSA HIV 1 <input type="checkbox"/> EXPOSED HBAB HCV HIV 1 |
| | <input type="checkbox"/> LEAD LEAD P | | |
| | <input type="checkbox"/> LIPASE LIP SST | | |
| | <input type="checkbox"/> MAGNESIUM MG SST | | |
| | <input type="checkbox"/> PROSTATE SPECIFIC AG PSA SST | | |
| | <input type="checkbox"/> RPR (STS) STS SST | | |
| | <input type="checkbox"/> T3 FREE FRE3 SST | | |
| | <input type="checkbox"/> T4 FREE FT4 SST | <input type="checkbox"/> MISC. CULTURE CULM SOURCE: [] | |
| | <input type="checkbox"/> TSH TSH SST | | |
| | <input type="checkbox"/> URIC ACID UA SST | | |

SYMPTOMS / DIAGNOSIS (mandatory to support test request)

Print Physician Name

Ordering Provider Signature

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