**MEDICAL DIRECTOR**
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23845 MCBEAN PARKWAY • VALENCIA, CA 91355
Phone (661) 200-1290

# LABORATORY SERVICES TEST REQUEST FORM

LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ___

SPECIMEN COLLECTED DATE ______ REFERRING PHYSICIAN ______

❑ FASTING ❑ NON-FASTING

TIME ______ ❑ AM ❑ PM COLLECTED BY ______ V

❑ PATIENT SELECTED LAB______ EMPLOYEE INITIALS

❑ STAT ❑ ROUTINE CALL ______ FAX ______

RESPONSIBLE PARTY NAME (If other than Patient) ______

ADDRESS ______ PATIENT E-MAIL ______

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

Date of Surgery:______

STATE ______ ZIP ______ PHONE ( ) ______ MR# ______

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:** ❑ DOCTOR ❑ PATIENT ❑ INSURANCE ❑ MEDI-CAL ❑ WKR. COMP

INSURANCE COMPANY ______ POLICY # ______

SUBSCRIBER'S NAME ______ SS NO. ______

ADDRESS ______ GROUP # ______

MEDI-CARE/MEDI-CAL # ______ RELATIONSHIP ______

CITY ______ STATE ______ ZIP ______

EMPLOYER ______

PHONE NO. ______

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-9 (CODES) 1.______ 2.______ 3.______ 4.______ 5.______ 6.______ 7.______

**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 | ICD-9

### PANELS

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

### INDIVIDUAL TESTS

| Test | Code | Tube |
|---|---|---|
| ❑ CBC w/Auto Diff | 85025 | L |
| ❑ CBC w/o Diff | 85027 | L |
| ❑ HIV - 1 & 2 Antibody* ❑ | 86703 | S |
| ❑ Prostate Specific Antigen | 84153 | S |
| ❑ Partial Thromboplastin Time | 85730 | B |
| ❑ Prothrombin Time | 85610 | B |
| ❑ Sed Rate, auto | 85652 | L |
| ❑ RA Factor, qt | 86431 | S |
| ❑ ANA | 86038 | S |
| ❑ Hemoglobin A1C | 83036 | L |
| ❑ Urinalysis* (Urogram) ❑ | 81003 | U |
| ❑ Urinalysis* w/reflex to Culture* | | U |

### CHEMISTRY

| Test | Code |
|---|---|
| ❑ Ab Screen* ❑ | 86850 |
| ❑ ABO ❑ RH | 86900/86901 |
| ❑ Alb | 82040 |
| ❑ Alk Phos | 84075 |
| ❑ ALT | 84460 |
| ❑ AST | 84450 |
| ❑ D.Bili | 82248 |
| ❑ T.Bili | 82247 |
| ❑ BUN | 84520 |
| ❑ Ca | 82310 |
| ❑ Chol | 82465 |
| ❑ CK | 82550 |
| ❑ Cl | 82435 |
| ❑ $CO_2$ | 82374 |
| ❑ Creat | 82565 |
| ❑ GGT | 82977 |
| ❑ Gluc | 82947 |
| ❑ HAAb IgM | 86709 |
| ❑ HBcAb IgM | 86705 |
| ❑ HBsAg* ❑ | 87340 |
| ❑ HDL | 83718 |
| ❑ HepCAb* ❑ | 86803 |
| ❑ K | 84132 |
| ❑ LDH | 83615 |
| ❑ Mg | 83735 |
| ❑ Na | 84295 |
| ❑ Phos | 84100 |
| ❑ Rubella | 86762 |
| ❑ RPR* ❑ | 86592 |
| ❑ T.Protein | 84155 |
| ❑ Trig | 84478 |
| ❑ Uric Acid | 84550 |
| ❑ T3 Total | 84480 |
| ❑ T4 Total | 84436 |
| ❑ TSH* ❑ | 84443 |
| ❑ Free T4 | 84439 |

❑ SARS-COV2 RNA TEST (COVID-19 PCR)

Source: ( Preadmission Clinic to check one)

❑ Nasophayngeal Swab

❑ MidTurbinate Nasal Swab

❑ Other:______

**Preadmission Testing Clinic:**

For appointments , call 661-200-1391
Fax orders to 661-200-1216 or email to preopdocs@henrymayo.com

______ Physician's Signature ______ Date ______ Time

### MICROBIOLOGY | ICD-9

❑ Source:______

❑ Urine C/S* ❑
❑ Stool C/S* ❑
❑ Routine C/S & Gram Stain* ❑
❑ Routine C/S w/o Gram Stain* ❑
❑ Anaerobic Culture* ❑
❑ Fungal Culture* ❑
❑ Viral Culture* ❑
❑ AFB Culture* ❑
❑ Occult Blood
❑ Gram Stain
❑ O & P (Traditional)
❑ O & P (Crypto/Giardia only)
❑ Chlamydia by DNA
❑ GC by DNA

*These tests may be reflexed based on test result; select ❑ if reflex not required. Reflex test listing listed on the back side of the requisition.

**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).

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

| L | B | GR | R | S | FS | U | PAP | Swab | OTHER |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

HM-RQ-VERS 13 REV 6/18

IMAGE PRINTING SOLUTIONS (949) 754-9000