Logan Health Medical Center Laboratory

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TEST CATALOG ONLINE: https://logan.testcatalog.org

Location

☐ Skilled ☐ Unskilled

Date: _____

PATIENT INFORMATION

Patient Legal Name (Last / First) _____/_____

Address _____ Zip _____

Date of Birth ____/___/____ **Gender**: ○ Male ○ Female **Phone:** ____-____-_____

INSURANCE | BILLING INFORMATION

Subscriber Name & Relationship _____

Insurance_____

Subscriber ID _____Date of Birth___/___/____Group #_____

Address _____

City/State/Zip _____Phone____-_____-_____

Bill To: ☐ Self Pay ☐ Insurance ☐ Client _____

☐ Medicaid ☐ Medicare #_____

Ordering Provider & Dx/ICD

Diagnosis/Codes _____

_____

_____

Provider Full Name (Print)

_____

Provider Signature (Required)

Medical Necessity Regulations: When ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, the tests must meet the following conditions: (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.

Copy To:

Specimen Collection

Date ____/____/____ Collection Time ____:____ AM | PM ☐Fasting ☐Non-Fasting

URINALYSIS-Must indicate collection type & test

☐ Clean Catch ☐ Cath ☐ Pedi bag ☐ _____

○ Urine Chemstrip - **URCS** Only ○ Urine Microscopic – **UMIC-NOR** Only ○ Urinalysis - **UAR** (Culture if indicated) ○ Urine Microscopic-**UMIC-.R** (Culture if indicated)

Test Name	Tube	Test Name	Tube	Test Name	
○ A1c/Glycohemoglobin	L	○ Folate	S	○ Progesterone	S
○ Ab Screen	P	○ FSH	S	○ Prolactin	S
○ ABO & Rh/Grp & Type	L	○ Gluc Tolerance, DM 2 hr	GY	○ Prot/Creat Ratio, Urine	U
○ ANA Screen	S	○ Gluc Tolerance, Gest	GY	○ PSA Screen	S
○ ANA Cascade	S	○ Glucose 1hour Challenge	GY	○ PSA Diagnostic	S
○ Anti CCP	S	○ HBsAg	S	○ PT / Protime / INR	B
○ Anti-HBS	S	○ hCG, Qualitative	U,S	○ PTH (Parathyroid Hormone)	S
○ Arthritis Panel	S,L	○ hCG, Quantitaitive	S	○ PTT	B
○ AST	S	○ HCT, Hematocrit	L	○ Quantitative M-Protein Study	S
○ BMP	S	○ HCV, Ab	S	○ RA (Rheum factor)	S
○ B12	S	○ HCV Quant, PCR	S	○ Reticulocyte Count	L
○ CA125	S	○ Health Screen	S,L	○ Rubella, IgG	S
○ CA27,29	S	○ Hgb	L	○ Rubeola, IgG	S
○ Calcium, Urine, Hours___	U	○ Hgb & Hct/H&H	L	○ Syphilis (Treponema AB)	S
○ CBC (Includes Diff)	L	○ Hepatitis Acute Panel	S	○ T3 Free / FT3	S
○ CBCND (No Diff)	L	○ Hepatitis Chronic Panel	S	○ T3 Total	S
○ CK	G	○ HIV 1,2 Antibody	S	○ T3 Uptake	S
○ CK-MB	G	○ IgG, Total	S	○ T4 Free / FT4	S
○ CMP	S	○ Insulin	S	○ T4 Total	S
○ Creat Clearance Wt_____Ht_____	U,S	○ Iron	S	○ T7 (T4, T3U)	S
		○ Iron Profile (Iron and IBC)	S	○ Tacrolimus	L
○ Creatinine, Urine, Hours_____	U	○ Lipid Panel	S	○ TB QuantiFeron, Gold +	SPEC
○ Creatinine	S	○ Liver Panel/Hepatic Panel	S	○ Testosterone, Total	R
○ CRP, Quantitative	S	○ Magnesium	S	○ Testosterone, Free / Total	R
○ CRP, HS	S	○ Microalbumin, Urine, Random	U	○ TPO,Thyroperoxidase	R
○ D Dimer	B	○ Mono	S	○ Troponin	G
○ Digoxin	S	○ Mumps, IgG	S	○ TSH	S
○ Dilantin/Phenytoin	S	○ OB P Basic	SPL	○ TSH, Reflex	S
○ ESR/Sed Rate	L	○ PFA P2Y12-Plavix/Effient	SPEC.B	○ Type & Screen	P
○ Estradiol	S	○ PFA PLT Function Screen	SPEC.B	○ Uric	S
○ Factor II Prothrombin Mutation	L	○ Phosphorus	S	○ Urine Drug Screen	U
○ Factor V Leiden	L	○ Platelet Count	L	○ Valproic Acid	S
○ Ferritin	S	○ Potassium	S	○ Vit D 25-OH	S
○ Fibrinogen	B	○ Procalcitonin / PCT	S	○ VZPG-Varicella Zoster, IgG	S

Therapeutic Drug Test – Last Dose Taken

Date ____/_____/_____ Time _____:_____ AM/PM

Microbiology and Molecular Tests

MUST SPECIFY SOURCE & SITE

Type of specimen: _____

Location on body: _____

Patient Antibiotics:

Culture (list source/site above)

- ○ Acid Fast culture & stain
- ○ Aerobic culture w/Gram stain
  - ☐ Abscess
  - ☐ Body Fluid
    - ○ Peritoneal/Ascites
    - ○ Pleural
    - ○ Synovial
  - ☐ Bronchial Washing
  - ☐ CSF
  - ☐ Eye
  - ☐ Sinus
  - ☐ Sputum
  - ☐ Tissue
  - ☐ Wound
- ○ Aerobic culture
  - ☐ Blood (Adult/Peds)
  - ☐ Catheter tip
  - ☐ Ear
  - ☐ Genital
  - ☐ Throat
  - ☐ Urine
    - ○ Clean catch
    - ○ Straight Catheter
    - ○ Indwelling Catheter
    - ○ Other _____
- ○ Anaerobic culture
- ○ Fungal culture –or– ○ Fungal w/ stain
- ○ Gram stain
- ○ Referral (ID/Susceptibility)
- ○ Screen for Single Organism (SSO) Organism: _____
- ○ Sterility Monitoring Device: _____

Microbiology Other

- ○ Blood-Borne Parasites Travel History: _____
- ○ C. difficile Screen
- ○ Fecal Fat (Qualitative)
- ○ Fecal Lactoferrin (WBC)
- ○ FIT Screen
- ○ Gastroccult
- ○ India Ink
- ○ KOH Prep
- ○ Ova & Parasite – Travel: _____
- ○ Pinworm Detection

Molecular Test by PCR

- ○ Bordetella Pertussis
- ○ Chlamydia: ○ ***Swab*** ○ ***Urine***
- ○ COVID-19
- ○ GAS (Group A Strep)
- ○ GBS (Group B Strep)
- ○ GI Bacterial Panel
- ○ GI Viral Panel
- ○ GI Parasite Panel
- ○ GC/ N. gonorrhea: ○ ***Swab*** ○ ***Urine***
- ○ HSV 1,2 (Dermal)
- ○ HPV
- ○ Influenza A/B
- ○ Meningitis, CSF Panel
- ○ MRSA Nares
- ○ MRSA / SA Nares
- ○ MRSA / SA Wound
- ○ Mycobacterium Tuberculosis (TB)
- ○ Norovirus GI, GII
- ○ RSV
- ○ Respiratory Panel
- ○ Varicella-Zoster (VZV - Dermal)
- ○ Vaginosis Panel

Special Instructions/Other Lab Tests

☐ **STAT** ○ Call Results Phone # ____-_____-_____

_____

_____

_____

R=Red_____ **L=**Lav_____ **BF=**Body Fluid____ **PAP=**PAP_____ **FR=**Frozen_____

S=SST_____ **P=**Pink_____ **U=**Urine_____ **UTM**_____ **SW=**Swab_____

B=Blue_____ **G=**Green_____ **ST=**Stool_____ **SWU=**Universal Kit _____

GY=Gray_____ **SER=**Serum_____ **PL=**Plasma_____ **SP B=**Special Blue_____

***Special Tube Instructions:**