Laboratory Requisition Form, Wellness

Pro-GeneX Laboratories, Inc.
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Collection Date/Time/Collectors Initials: ____ /____ /____ DIAG/ICD10 Code: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

PATIENT ADDRESS: _____

DOB: _____ SS# _____ PHONE: _____ GENDER: MALE or FEMALE

OFFICE NAME: _____ ORDERING PHYSICIAN: _____

BILL TO: INSURANCE PATIENT MEDICARE MEDICAID OFFICE/DOCTOR

INSURANCE COMPANY: _____ POLICY/GROUP# _____

INSURED NAME: _____ DOB: _____ RELATIONSHIP: _____

CHEMISTRY PROFILES (SERUM SEPARATOR TUBE) Circle Requested Profiles

Acute Hepatitis Profile **(LAB551)**
Basic Metabolic Panel **(LAB15)**
Comprehensive Metabolic Panel **(LAB17)**
Electrolyte Panel **(LAB16)**
Hepatic Function Panel **(LAB20)**
Lipid Panel **(LAB18)**
Renal Function Panel **(LAB19)**
Thyroid (FT4/TSH) Panel **(LAB9942)**

Alkaline Phosphatase **(LAB112)**
AST/SGOT **(LAB131)**
ALT/SGPT **(LAB132)**
Amylase **(LAB48)**
Bilirubin, Direct **(LAB52)**

Bilirubin, Neonatal **(LAB51)**
Bilirubin, Total **(LAB50)**
BUN **(LAB140)**
CA 125 **(LAB155)**
Calcium **(LAB53)**
CEA **(LAB57)**
Total Cholesterol **(LAB60)**
Total CPK **(LAB62)**
CRP **(LAB149)**
Creatinine **(LAB66)**
Estradiol **(LAB523)**
Estrogens, Fractionated **(LAB980)**
Ferritin **(LAB68)**
Folate **(LAB69)**

FSH **(LAB86)**
GGT **(LAB85)**
Glucose, Fasting **(LAB81)**
HIV **(LAB473)**
Iron **(LAB94)**
Iron/TIBC **(LAB829)**
Lutenizing Hormone **(LAB87)**
Magnesium **(LAB103)**
Mono **(LAB482)**
Phosphorous **(LAB113)**
Potassium **(LAB114)**
Pregnancy Test, Qualitative **(LAB144)**
Pregnancy, Qualitative **(LAB143)**

Progesterone **(LAB529)**
Protein, Total **(LAB118)**
Protein Electrophoresis **(LAB119)**
Protein Electrophoresis w/reflex Immuno **(LAB9946)**
PSA, Screening/Routine **(LAB116)**
PSA, Diagnostic/Symptoms **(LAB1076)**
Rubella **(LAB496)**
RPR **(LAB494)**
Sodium **(LAB122)**
Testosterone, Male **(LAB124)**
Testosterone, Female/Child **(LAB459)**
T3, Free **(LAB137)**
T4, Free **(LAB127)**
Triglycerides **(LAB134)**

Uric Acid **(LAB141)**
Vitamin B12 **(LAB67)**

LAVENDER TOP (EDTA)

CBC w/Diff **(LAB1748)**
CBC wo/Diff **(LAB294)**
HGB AIC **(LAB90)**
Retic Count **(LAB296)**
Sed Rate/ESR **(LAB322)**

BLUE TOP (SODIUM CITRATE)

DDIMER **(LAB313)**
Fibrinogen **(LAB314)**
Protime/INR **(LAB320)**
PTT **(LAB325)**

URINE TEST

Urinalysis, Routine **(LAB347)**
Urinalysis, Reflex to Culture **(LAB9967)**
Urine Pregnancy **(LAB437)**
Drug Quick Screen **(LAB9638)**

24 HR URINE TESTING

Height: _____ inches
Weight: _____ LBS
Urine Total Volume: _____ ml
Creatinine Clearance **(LAB1765)**
Must send Serum for creatinine

Creatinine **(LAB712)**
Protein **(LAB441)**

SPECIAL PROFILES

Arthritis Panel **(LAB9966)** GOLD/LAV
Anemia Profile **(LAB9464)** GOLD/LAV

OB TESTING/BLOOD BANK LAVENDER TOP (EDTA)

Antibody Screen **(LAB278)**
Blood Type **(LAB895)**
Fetal Fibronectin **(LAB287)**
Maternal 2nd Trimester/Screen **(LAB9724)** AND Patient information FORM by Gold top
Prenatal Profile **(LAB948/LAB9293)** (Draw Gold/Lavender)

MICRO TESTING

Acid Fast Culture/ Smear
Anaerobic Culture **(LAB233)**
Beta Strep, Group B Screen **(LAB1377)**
Blood Culture **(LAB462)**
Body Fluid Culture, **(LAB269)**
Clostridium Difficile, PCR **(LAB253)**

Chlamydia/Gonorrhea **(LAB1376)**
Urine or Female cervical swab
Culture, Routine/ Aerobic
With gram stain **(LAB899)**

Ear Culture **(LAB942)**
Eye Culture **(LAB943)**
Fungus Culture/Smear **(LAB1294)**
Throat Culture **(LAB228)**
Strep Screen **(LAB885)**
Stool Culture **(LAB223)**
Stool WBC Screen **(LAB265)**

Stool Occult Blood **(LAB921)**
Ova/Parasite Screen **(LAB258)**
Urine Culture **(LAB239)**
Sputum Culture **(LAB9994)**

MUST PROVIDE SOURCE

SOURCE: _____

COMMENTS AND/OR OTHER TEST NOT LISTED

Call To: _____

Fax To: _____

ADVANCE NOTICE OF Noncoverage of Outpatient Laboratory Services

This is to advise you that based on our understanding of current Medicare coverage policy, the laboratory test(s) selected above, are not covered by Medicare because:

A ☐ Medicare does not pay for routine screens or annual physicals; **B** ☐ Medicare does not pay for this service for your condition; or

C ☐ Medicare does not pay for research or investigational use tests.

This is to acknowledge that I received this notice of noncoverage of services under Medicare in person on the date I have indicated below. I understand that Medicare will not pay for the laboratory tests indicated above and agree to be personally and fully responsible for payment.

X _____ Date: _____ PATIENT SIGNATURE

X _____ Date: _____ WITNESS SIGNATURE