McLaren

BAY REGION
LABORATORY OUTPATIENT TEST REQUEST FORM

TO PRE-REGISTER, CALL 667-6326 OR 1-888-922-9633 or mclaren.org/bayregion/onlinepreregistration

☐ STAT - EXPEDITE RESULTS TO: _____
☐ Fax ☐ Call (Number) _____

LABORATORY PHONE (989) 894-3752 FAX (989) 894-5744
• TESTS MAY REQUIRE ADVANCED BENEFICIARY NOTICE.

PATIENT INFORMATION

PATIENT NAME | ☐ MALE ☐ FEMALE
STREET ADDRESS
CITY | STATE | ZIP CODE
SOCIAL SECURITY NUMBER | DATE OF BIRTH | PATIENT TELEPHONE NUMBER

BILLING INFORMATION

PRIMARY INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ OTHER | PATIENT IS: ☐ SUBSCRIBER ☐ SPOUSE ☐ OTHER
INSURANCE COMPANY NAME
INSURANCE MEMBER / ID # | GROUP #
INSURANCE ADDRESS | SUBSCRIBER NAME
MEDICARE / MEDICAID # | SUBSCRIBER DOB

SECONDARY INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ OTHER | PATIENT IS: ☐ SUBSCRIBER ☐ SPOUSE ☐ OTHER
INSURANCE COMPANY NAME
INSURANCE MEMBER / ID # | GROUP #
INSURANCE ADDRESS | SUBSCRIBER NAME
MEDICARE / MEDICAID # | SUBSCRIBER DOB

ICD CODES ARE REQUIRED FOR INSURANCE BILLING. THE CODES PROVIDED ARE NOT ALL-INCLUSIVE; CONSULT THE ICD-10 MANUAL FOR A COMPLETE LISTING.

DIAGNOSIS CODES MUST BE MEDICALLY APPROPRIATE FOR THE PATIENT'S CONDITION AND CONSISTENT WITH DOCUMENTATION IN THE PATIENT'S MEDICAL RECORD

☐ N91.2	ABSENCE OF MENSTRUATION	☐ R30.0	DYSURIA	☐ Z34.90	PREGNANCY	☐ N39.0	URINARY TRACT INFECTION
☐ D64.9	ANEMIA NOS	☐ E78.0	HYPERCHOLESTEROLEMIA	☐ 020.0	THREATENED ABORTION	☐ N76.0	VAGINITIS OR VULVITIS
☐ N72	CERVICITIS	☐ N92.0	MENORRHAGIA	☐ 060.03	THREATENED PRETERM LABOR, 3RD TRI	☐ N89.8	VAGINAL DISCHARGE
☐ N93.8	DUB	☐ R10.2	PELVIC PAIN	☐ 060.02	THREATENED PRETERM LABOR, 2ND TRI	☐ OTHER	_____

☐ PATIENT SHOULD BE **FASTING**_____ HOURS, NOTHING TO EAT OR DRINK PRIOR TO BLOOD DRAWING ☐◆ 12 HRS. ☐◆◆ 8 HRS.

SAMPLE COLLECTION DATE / TIME

ORGAN / DISEASE PANELS

☐ **ELECTROLYTE PANEL** (Na, K, Cl, CO2)
•☐ **HEPATIC (LIVER) FUNCTION PANEL** (Alb, TBili, DBili, AP, AST, ALT, TP)
•☐ **BASIC METABOLIC PANEL** (Na, K, Ca, Cl, CO2, Glu, BUN, Cr) ◆◆
•☐ **COMP METABOLIC PANEL** ◆ (Na, K, Cl, CO2, Glu, BUN, Cr, Ca, TP, Alb, TBili, AP, AST, ALT)
F•☐ **LIPID PANEL** (Fasting Specimen) ◆ (TChol, Trig, HDL, calc LDL)
☐ **OBSTETRIC PANEL W/REFLEX** (ABO/Rh, Antibody Scr RBC, CBC, RPR, HbsAg, Rubella IgGAb)

OTHER TESTS

☐ ANTIBODY SCREEN
☐ B-12 ☐ FOLATE ◆◆
•☐ Beta-hCG (Quant.-Serum)
☐ BUN
☐ CALCIUM
•☐ CBC WITH DIFF
•☐ CBC WITHOUT DIFF
F•☐ CHOLESTEROL TOT. ◆◆
F•☐ CHOLESTEROL HDL ◆◆
F•☐ CHOLESTEROL LDL ◆◆
☐ CREATININE WITH GFR
☐ ESTRADIOL
•☐ FERRITIN
☐ FETAL FIBRONECTIN
☐ FSH ☐ LH
• GLUCOSE:
☐ FASTING ☐ RANDOM
F•☐ GLUCOSE TOL
_____ HR ☐ OB SCRN 1 HR 50 GM
☐ HEP B SURFACE AG
☐ HEP C VIRUS AB
☐ HERPES TYPE I & TYPE II, IgG & IgM
☐ OTHER
F•☐ HIV
•☐ IRON •☐ IRON BINDING CAP.
•☐ MAGNESIUM
☐ POTASSIUM
F•☐ PREGNANCY (QUAL.)
☐ SERUM ☐ URINE
☐ PROGESTERONE
☐ PROLACTIN
•☐ RPR
☐ RhoGam
☐ RUBELLA ANTIBODIES, IgG
☐ SGOT (AST) ☐ SGPT (ALT)
☐ TYPE & SCREEN
F•☐ THYROID CASCADE
F•☐ TSHF F•☐ T-4 FREE
☐ URIC ACID
☐ URINALYSIS Reflex Microscopic if Pos
☐ Urinalysis with Microscopic
☐ Urinalysis with Microscopic
• Culture if Indicated
☐ URINE DRUG SCREEN
☐ VARICELLA ZOSTER-IgG & IgM

☐ ALPHA-FETOPROTEIN (AFP) SCREEN

(AFP Maternal/Estriol, Unconjugated/hCG, Total/hCG, Free alpha-subunit)
Birth Date_____ Weight _____ Lbs./Kg. _____

Insulin Dependent Diabetic? ☐ Yes ☐ No — Select yes if patient was on insulin prior to this pregnancy

Race: ☐ Black ☐ Other

Twin Pregnancy? ☐ Yes ☐ No — Risk estimates are not available for triplets or Diabetic twin pregnancies. If one twin is deceased, select No

In-Vitro Fertilization? ☐ Yes ☐ No Donor DOB: _____ (if other than Patient)

If frozen egg or embryo used, how long frozen: _____ Years _____ Months

Has patient had previous pregnancy with Down Syndrome (trisomy21) or other trisomy? ☐ Yes ☐ No
Is this a repeat serum Screen? ☐ Yes ☐ No
If yes, previous control number _____

EDD_____ By_____ U/S or ____ LMP — Ultrasound dating increases screening performance. - Required for twins.

NTD assessment not available before 15 weeks by ultrasound; 16-18 weeks preferred.
Down Syndrome & Trisomy 18 assessment available 14 weeks, 0 days - 22 weeks 6 days.

MICROBIOLOGY

ROUTINE CULTURE / SOURCE (REQUIRED): _____

☐ CHLAMYDIA/GC DNA PROBE
☐ CHLAMYDIA DNA PROBE/PCR
☐ STREP SCREEN CULTURE
•☐ URINE CULTURE MIDSTREAM
☐ VAGINAL CULTURE
☐ HPV
☐ GC DNA PROBE/PCR
☐ THROAT CULTURE
•☐ URINE CULTURE CATH
☐ VIRAL CULTURE

For any patient or any payer (including Medicare and Medicaid), only order those tests which are medically necessary for diagnosis and treatment of the patient.

SIGNATURE OF PHYSICIAN X | DATE SIGNED | **COPY OF REPORT TO:**

• Test may require advanced beneficiary notice (ABN)
F• Frequency limits may require ABN

ADDRESSOGRAPH

100B

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