

St. Mary's Hospital Laboratory Requisition
P.O. Box 1628 Grand Junction, CO 81502-1628
(970) 298-2071 (Phone)
(970) 298-2286 (Fax)

AD Long, MD
RA LaCount, MD

HS Mooney, MD
TL Marshall, MD

CLIA ID # 06D0519294

Priority Testing
☐ STAT

COLLECTION DATE: ____/____/____
COLLECTION TIME: ____ AM ____ PM

Fasting: ☐ Yes ☐ No

Requesting Physician / Provider <input type="checkbox"/>	Phone Number	Copy To
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PATIENT AND BILLING INFORMATION (Please Print) Please provide complete information, including insurance card copy

Last Name	First Name	Initial	Previous Name	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address	City	State	Zip	Phone Number	Social Security Number
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Person Responsible For Bill	Patient's Relationship to Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Client / Physician Billing CHECK BOX IF PHYSICIAN OFFICE IS TO BE BILLED <input type="checkbox"/>
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Address of Person Responsible for Bill (If different from above)	Phone Number	Social Security Number of Person Responsible
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Primary Insurance Company	Primary Insurance Company Address	Subscriber Number / ID Number	Group Number
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INSURANCE SIGNATURE AUTHORIZATION

The undersigned directs payment to St. Mary's Hospital of any insurance benefits otherwise payable to or on behalf of the undersigned for laboratory services rendered. It is understood by the undersigned that he/she is financially responsible for the charges not covered by the insurance company. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at a rate of 1% per month (12% annum).

Signature of Financially Responsible Party: _____ Date: _____ Time: _____

PHYSICIAN ICD DIAGNOSIS REQUIREMENT NOTICE

When ordering tests, be informed that the physician (or other authorized individual) is required to (1) submit ICD code information, supported by the patient medical record, as documentation of the medical necessity of the tests ordered, or (2) explain and have the patient sign an Advanced Beneficiary Notice (ABN). Complete the ABN only if there is reason to believe that Medicare will deny payment.

ICD Codes: _____

1) Mark appropriate box 2) Limited Coverage Tests 3) *Reflex testing: see back page

Prenatal Testing

- ☐ AFP (Only)
☐ Triple Screen AFP / HCG / Estriol, Maternal
☐ Quad Screen AFP / HCG / Estriol / Inhibin

Required Patient Information

Date of Birth: ____/____/____
Current Weight: _____ lbs
Due Date (EDC): ____/____/____

Determined by:
☐ Last Menstrual Period ☐ Ultrasound

Date of last menstrual period: ____/____/____
Is current pregnancy

- ☐ Singleton ☐ Twins
☐ Triplets ☐ Unknown

What is the patient's race?

- ☐ Caucasian ☐ Black
☐ Hispanic ☐ Other

Does the patient require insulin to control diabetes?
☐ Yes ☐ No

Is there a history of neural tube defect?
☐ Yes ☐ No

If Yes, what is the relationship to the fetus?

Is this a repeat sample?
☐ Yes ☐ No ☐ Unknown

Prenatal Testing

- ☐ Obstetric Panel
☐ **HIV Antibody, Screening, GR
☐ **HIV Antibody, Diagnostic, GR
☐ Urinalysis
☐ ABO and Rh (Type).
☐ Antibody Screen
☐ **CA 125, GR/GO
☐ Estradiol, GR/GO
☐ FSH, GR/GO
☐ **Glucose GR/GO
☐ Glucose OB Screen, GR/GO
☐ Glucose OB Diagnostic, 3°
☐ HCG, Serum Pregnancy, GR/GO
☐ HCG, Quantitative, GR/GO
☐ *Hep B Core AB, Total, GO
☐ Hep B Surface Antigen, GO
☐ Hep C Virus Antibody, Screening, GO
☐ Hep C Virus Antibody, Diagnostic, GO
☐ Luteinizing Hormone, GO
☐ Progesterone, GO
☐ Prolactin, GR/GO
☐ Testosterone, GO
☐ **T4, Free, GR/GO
☐ **TSH, GR/GO
☐ **TSH Reflex, GR/GO

Fluids

- ☐ Fetal Fibrinectin
☐ Semen Analysis/Fertility

4) **National Coverage Decisions (NCD): see back page

Microbiology - culture request must include source

- ☐ **Urine Culture ☐ Mid Stream ☐ Cath ☐ Supra
☐ Backup Beta Strep
☐ Group B Strep Screen (Genital) ☐ Susceptibility Requested
☐ EPMA (Enteric Pathogen Molecular Assay)
☐ Ova & Parasites
☐ Respiratory Culture: ☐ Sputum
☐ Chlamydia Molecular Assay Source: _____
☐ Gonorrhea Molecular Assay Source: _____
☐ *Wound Culture Source: _____
☐ Fecal Occult Blood, Screening
☐ Fecal Occult Blood, Diagnostic
☐ C. Diff. Toxin by PCR
☐ Respiratory Panel by PCR
☐ Rapid Testing: ☐ Strep A ☐ Influenza ☐ RSV
☐ H. Pylori Fecal Antigen
☐ Bordetella Molecular Assay
☐ Herpes Molecular Assay

Hematology / Coagulation

- ☐ **Hematocrit, L
☐ **Hemoglobin, L
☐ **Hemogram + Platelet, L
☐ **CBC / Differential, L
☐ **Platelet Count, L
☐ **Prothrombin Time (PT), B
☐ Custom Panel (refer to back page)
☐ Pregnancy Induced Hypertension
☐ Organ or Disease Oriented Panels (refer to back page)
☐ Basic Metabolic, GR/GO
☐ Comprehensive Metabolic, GR/GO
☐ **Lipid Panel, GR/GO

Additional Testing / Instructions:

Signature: _____ Date: _____ Time: _____

FOR LAB USE ONLY

☐ ABN ☐ Veno Init: _____ ☐ AMP, LB ☐ MB ☐ LB

PT ID-OK: _____ Spec Name: _____

Specimens: _____ Initials: _____ Date: _____ Time: _____

Req #: _____ Initials: _____ Date: _____ Time: _____

DE Audit Initials: _____ Date: _____ Time: _____



St. Mary's
MEDICAL CENTER | SCL Health

2635 N. 7th Street, Grand Junction, CO 81501-8209



* O N O B O *

OB/GYN Services Laboratory Requisition

White Copy - Lab
3010139 Rev. 09/16

Yellow Copy - Provider

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is
outside this guide.

Draw Station Locations

Revised: 11/2014

Advanced Medical Pavilion Laboratory Services
750 Wellington Avenue, Entrance 22
Hours: M – F 7:00 AM to 5:00 PM

St. Mary's Hospital Laboratory Draw Station
SMH, Main Floor, Entrance 1, 2, or Parking Garage Walk way
Hours: 24 hours / 7 days a week

Organ or Disease Oriented Panels

Comprehensive Metabolic (80053)

Albumin (82040)
Bilirubin, Total (82247)
Calcium (82310)
Carbon Dioxide (82374)
Chloride (82435)
Creatinine (82565)
Glucose (82947)
Alkaline Phosphatase (84075)
Potassium (84132)
Protein, Total (84155)
Sodium (84295)
ALT (84460)
AST (84450)
BUN (84520)

Basic Metabolic (80048)

Calcium (82310)
Carbon Dioxide (82374)
Chloride (82435)
Creatinine (82565)
Glucose (82947)
Potassium (84132)
Sodium (84295)
BUN (84520)

Electrolyte (80051)

Carbon Dioxide (82374)
Chloride (82435)
Potassium (84132)
Sodium (84295)

Acute Hepatitis (80074)

Hepatitis B Surface Antigen
Hepatitis B Core Antibody, IgM
Hepatitis A Antibody, IgM
Hepatitis C Antibody

Hepatic Function (80076)

Albumin (82040)
Bilirubin, Total (82247)
Bilirubin, Direct (82248)
Alkaline Phosphatase (84075)
ALT (84460)
AST (84450)
Protein, Total (84155)

Obstetric (80055)

CBC (85022 or 85025)
Hep B Surface Antigen (87340)
Rubella (86762)
RPR (86592)
Antibody Screen (86850)
Blood Typing, ABO (86900)
Blood Typing, Rh (86901)

Lipid (80061) *

Cholesterol (82465)
Triglyceride (84478)
HDL (83718)

Renal Function (80069)

Albumin (82040)
Calcium (82310)
Carbon Dioxide (82374)
Chloride (82435)
Creatinine (82565)
Glucose (82947)
Phosphorous (84100)
Potassium (84132)
Sodium (84295)
BUN (84520)

Specimen Collection Container Key

Code	Collection Container
GO	GOLD
GR	GREEN
GR/GO	GREEN or GOLD
A	AMBER or RED protected from light
R	RED, no barrier
CL	Call Lab 298-2071 for more information
GO/R	GOLD or RED

Code	Collection Container
L	LAVENDER
IL	Iced LAVENDER (must be separated from cells & frozen within 1 hour)
B	BLUE
CU	Clean Catch Container
F	Critical Frozen, separate for cells ASAP & freeze
24°UR	24 Hour Urine Collection Container

Advanced Beneficiary Notice (ABN) Review; Screening Test (Medicare Program)

Title XVIII of the Social Security Act, section 1862 (a) (1) excludes routine physical checkup (including the absence of signs and symptoms) from the Medicare program. Screening is defined as examinations and/or diagnostic procedures performed in the absence of signs and symptoms. While election to perform such examinations and tests may be considered good medical practice, they are not covered services by the Medicare program. Even though laboratory tests performed for screening purposes are a program exclusion, and an ABN is not required, it is recommended that the provider/physician notify the patient in advance that Medicare will not cover the screening test and that the patient will be liable for the cost of the test.

Advanced Beneficiary Notice (ABN) Review; ** National Coverage Decisions (NCD) for the Medicare Program

St. Mary's Laboratory Services National Coverage Decision (NCD) is determined by Medicare Part B policies. The policies are published at www.cms.org and limit coverage on specified tests to specific ICD codes that support medical necessity. If the patient's ICD code/codes are not included in the NCD, refer to the Advanced Beneficiary Notice (ABN). Advise the patient of the reason for the non-covered service, of his/her responsibility for the cost of testing, and ask the patient to sign the ABN. The ABN needs to be submitted to the laboratory with the "Laboratory Services Requisition" at the time of service.

*Reflex Testing Performed by the Laboratory

***Lipid Extended:** A Lipid Panel is performed and billed unless the Triglyceride is > 400 mg/dL. If Triglyceride is > 400 mg/dL, a direct measured LDL Cholesterol will be performed and billed.

***TSH Reflex:** A TSH will be performed and billed unless the TSH is < 0.4 or > 4.9. If TSH is > 4.9, a Free T4 is performed and billed. If the TSH is < 0.4, a Free T4 is performed and billed. If the Free T4 is performed from a reflex and is normal, a Free T3 will be performed and billed.

***CBC:** If laboratory criteria for a manual differential are triggered, a Hemogram and a manual differential will be performed and billed. Oncology patients are an exception to this reflex at the request of the Oncology clinicians.

***Pathologist Smear Review:** If a slide review or manual differential from a CBC triggers a pathologist smear review, a Pathologist Smear Review will be performed and billed.

****All physician orders for a Pathologist Smear Review will trigger orders for a manual differential to be performed and billed.**

***Other Source Cultures:** If laboratory criteria is met for identification and sensitivities, these procedures will be performed and billed.

***Gram Stain:** A gram stain will be performed and billed for all cultures with the exception of Urine, Stool, Ear-Nose-Throat, Genital, or Strep Screen.

***Rapid Strep Screen:** A negative rapid strep screen will trigger a strep culture to be performed and billed.

***ANA:** A positive ANA will trigger an ANA titer to be performed and billed.

***AFB Culture:** An AFB culture will reflex an AFB Smear to be performed and billed.

***HIV:** A positive HIV will reflex a confirmatory test to be performed and billed.

***Treponemal Antibodies (Syphilis) (TPPA):** Positive TPPA will reflex a confirmatory test to be performed and billed.

***All abnormal serum protein electrophoresis showing a monoclonal protein not previously identified will trigger an immunoelectrophoresis to be performed and billed.**

***Hepatitis B Surface Antigen:** A positive result will reflex to a confirmatory test to be performed and billed.

Custom Panel: Physicians should order only those tests that are medically necessary. Using a customized panel may result in ordering tests for which Medicare/Medicaid will deny payment. The OIG takes the position that the physician who orders medically unnecessary tests may be subject to civil penalties.