University of Kentucky Hospital Chandler Medical Center - Lexington, KY	**BLOOD GAS LAB FORM**	PATIENT ID Patient Name:
DRAWN BY:	Accession #:	Med Rec #:
DATE AND TIME:		Date of Birth: M F

S		pH & BLOOD GAS TESTS	PATIENT DATA		
	PH	pH ONLY	TEMPERATURE:_____ FIO2_____% LPM_____		
	ABG	pH & **ARTERIAL** BLOOD GAS	**S**		**WHOLE BLOOD CHEMISTRY TESTS**
	VBG	pH & **VENOUS** BLOOD GAS		ICAWB	IONIZED CALCIUM
	CBG	pH & **CAPILLARY** BLOOD GAS		NAWB	SODIUM
	OBG	pH & **OTHER SITE** BLOOD GAS		KWB	POTASSIUM
		Specify Site:		GLUWB	GLUCOSE
	COOX	HEMOGLOBIN SATURATION		HCTWB	HEMATOCRIT
		(includes: T. HGB, OXYHEMOGLOBIN %SATURATION, REDUCED HGB)		LAWB	LACTATE
		Specify Site:		CLWB	CHLORIDE
	METHB	METHEMOGLOBIN			
	COHB	CARBOXYHEMOGLOBIN	**REASON**		
	THGB	TOTAL HEMOGLOBIN			

Ordering Provider Signature: _____ **ID #** _____ **Date:** _____ **Time:** _____

IF REQUESTING PROVIDER IS A RESIDENT, ATTENDING PHYSICIAN INFORMATION IS REQUIRED

	Requesting Provider	Attending Physician	Pager #	Telephone #
Full Name				

Primary Insurance _____ Secondary Insurance _____ **ICD-9-CM CODES**

If patient is covered by Medicare AND a highlighted test is ordered:

1) Has Medical Necessity check been completed for Medicare Part A? Y N NA
2) Has Medical Necessity check been completed for Medicare Part B? Y N
3) ABN: Required Discussed Signed

Clinic Staff Signature _____ Service: _____ Phone Number _____ Date _____

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