**For Penn Home Infusion Therapy use only**

Penn Medicine
Hospital of the University of Pennsylvania
3400 Spruce Street, Philadelphia, PA 19104

**DIVISION OF LABORATORY MEDICINE**
**Phone:** 215-662-4808 (24/7) • **FAX:** 215-349-8294

**Please PRINT Legibly**

**Affix Label**
HUP MRN: _____
Patient Name: _____
Date of Birth: _____
Gender: ☐ Male ☐ Female
*If label not available, information must be printed.*

**Patient Address:** _____

| Date Collected (required by law) | Time of Collection (required by law) | Name of Collector (required by law) | Collector Phone Number | Fasting |
|---|---|---|---|---|
| ____/____/____ | | | 1-800-666-6002 | ☐ Yes ☐ No |

| Ordering Physician (both Last Name and First Name Required) | Ordering Physician's Phone Number | Ordering Physician's NPI |
|---|---|---|
| _____, _____ (Last Name) (First Name) Specialty: _____ | Is the Ordering Physician a FAX BACK? ☐ Yes ☐ No | Ordering Physician's Fax Number |

| ICD Code #1 | ICD Code #2 | ICD Code #3 |
|---|---|---|
| | | |

PENN HOME INFUSION THERAPY

**Specimen Source (Required Information)**

**HEMATOLOGY**
- ☐ CBC
- ☐ CBC w/ Diff

**DISEASE PANEL**
- ☐ Basic Metabolic Panel (BMP)
- ☐ Comprehensive Metabolic Panel (CMP)
- ☐ Lipid Panel
- ☐ Liver Evaluation Panel (LFTs)

**OTHER TESTS**
- ☐ Albumin
- ☐ Alkaline Phosphatase
- ☐ ALT
- ☐ AST
- ☐ Amylase
- ☐ Bilirubin, Total
- ☐ Bilirubin, Direct
- ☐ NTproBNP
- ☐ BUN
- ☐ Calcium Total
- ☐ Carbon Dioxide
- ☐ Chloride
- ☐ Cholesterol Total
- ☐ CPK
- ☐ Creatinine
- ☐ Folate
- ☐ GGT
- ☐ Glucose Fasting
- ☐ Hemoglobin A1c
- ☐ High Density Cholesterol Group
- ☐ High Sensitivity CRP
- ☐ Iron/Transferrin/trnsat
- ☐ Iron
- ☐ Lipase
- ☐ LDH
- ☐ Magnesium
- ☐ Non-Cardiac CRP
- ☐ Phosphorus
- ☐ Potassium
- ☐ Prealbumin
- ☐ Protein,Total
- ☐ Sedimentation Rate
- ☐ Sodium
- ☐ Triglycerides
- ☐ TSH
- ☐ Uric Acid
- ☐ Vitamin B12
- ☐ Vitamin D, Total

**DRUG LEVELS**
- ☐ Amikacin Trough
- ☐ Case – Cytomegalovirus Quantitation (CMV-PCR)
- ☐ Digoxin Level
- ☐ Gentamicin Trough
- ☐ Tacrolimus Level
- ☐ Tobramycin Trough
- ☐ Vancomycin Trough
- ☐ Voriconazole

**MICROBIOLOGY**
Body Site: _____
- ☐ Blood Culture #1 Location: _____
- ☐ Blood Culture #2 Location: _____
- ☐ C.Difficile Toxin
- ☐ Routine Stool Culture
- ☐ Urine Culture

**URINE SPECIMENS**
- ☐ Microalbumin
- ☐ Urinalysis

**TRACE ELEMENTS**
- ☐ Chromium
- ☐ Copper
- ☐ Selenium
- ☐ Whole Blood Manganese
- ☐ Zinc

**PT**
☐ PT
Warfarin: ☐ Yes ☐ No

**Call Critical Results to:**
_____, _____ (Last Name) (First Name)
Phone: _____
Fax: _____
☐ CC ☐ FAX BACK

**ADDITIONAL TESTS:**
☐ _____ ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____

**ADDITIONAL PROVIDERS**

**CC (Active Epic Users)**

| NAME (Last Name, First Name) | SPECIALTY |
|---|---|
| | |
| | |
| | |
| | |

- ☐ PHIT Heme/Onc Team (14542)
- ☐ PHIT MSKR/Neurology Team (14543)
- ☐ PHIT HVC/Pulmonology/ID Team (14544)
- ☐ PHIT GI/GU/Nephrology Team (14545)
- ☐ AMC (2000369)
- ☐ HUP CNSS (2000318)
- ☐ IDTS HUP (11046)
- ☐ PPMCIDTS (1000342411088)

**Fax Back**

| NAME (Last Name, First Name) | FAX NUMBER |
|---|---|
| | |
| | |
| | |

**Special Instructions**
- There is a Fax Back limit of three physicians including ordering physician.
- If the patient is receiving only Catheter Care services at PHIT, do **NOT** select a PHIT Care Team in the CC section.