For Penn Home Infusion Therapy use only

Penn Medicine

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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 Solid Team (1100015)**
- ☐ **PHIT Heme/Onc Liquid 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.