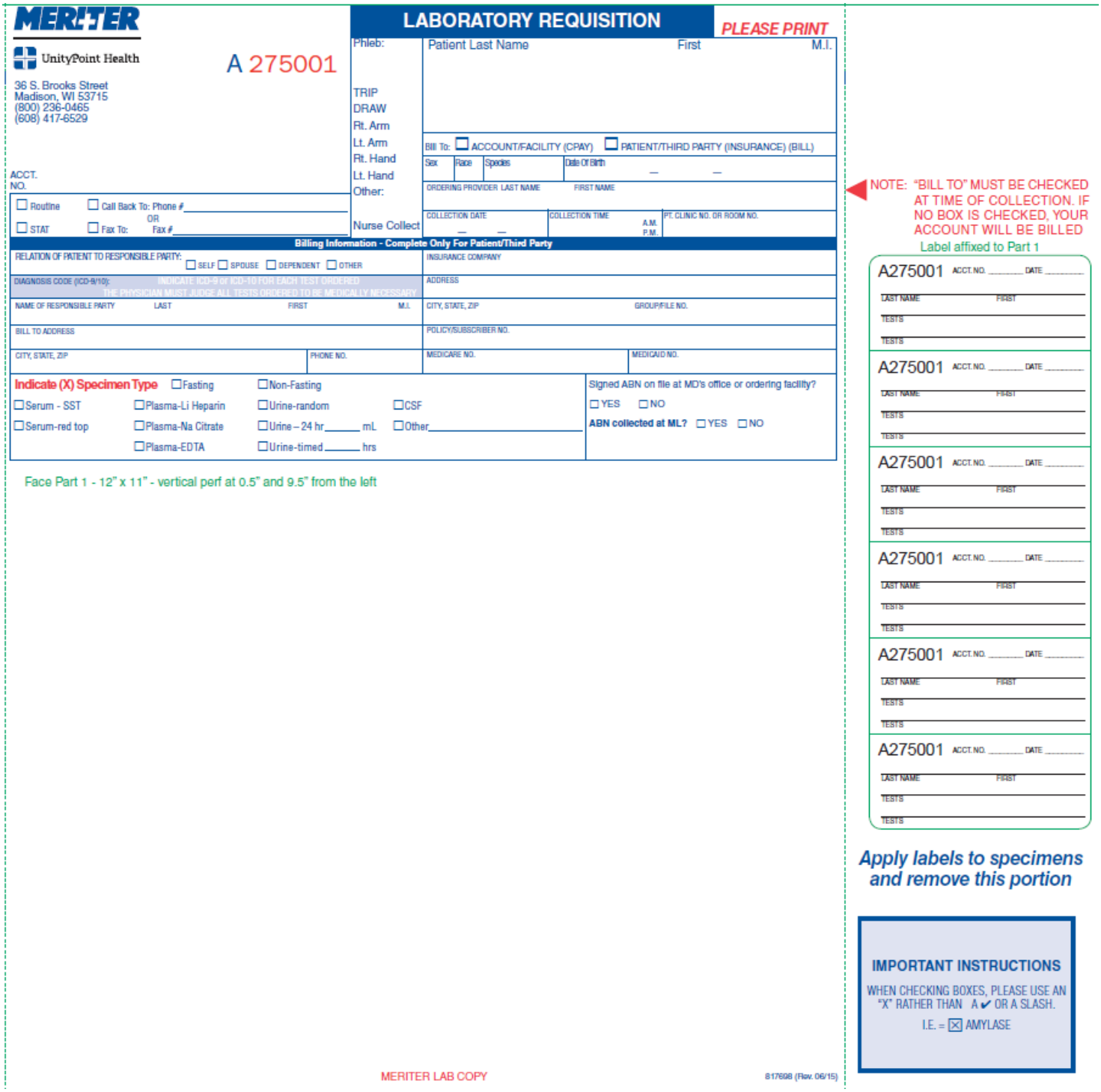
Requisitions, Consent Forms and Billing Information

Client Requisition



MERITER

UnityPoint Health

36 S. Brooks Street
Madison, WI 53715
(800) 236-0465
(608) 417-6529

A 275001

LABORATORY REQUISITION

PLEASE PRINT

Phleb:

TRIP
DRAW
Rt. Arm
Lt. Arm
Rt. Hand
Lt. Hand
Other:

Nurse Collect

Patient Last Name | First | M.I.

Bill To: ☐ ACCOUNT/FACILITY (CPAY) ☐ PATIENT/THIRD PARTY (INSURANCE) (BILL)

Sex | Race | Species | Date Of Birth

ORDERING PROVIDER LAST NAME | FIRST NAME

COLLECTION DATE | COLLECTION TIME A.M. P.M. | PT. CLINIC NO. OR ROOM NO.

ACCT. NO.

☐ Routine ☐ Call Back To: Phone # ☐ STAT ☐ Fax To: Fax # (OR)

Billing Information - Complete Only For Patient/Third Party

RELATION OF PATIENT TO RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

INSURANCE COMPANY

DIAGNOSIS CODE (ICD-9/10): INDICATE ICD-9 or ICD-10 FOR EACH TEST ORDERED
THE PHYSICIAN MUST JUDGE ALL TESTS ORDERED TO BE MEDICALLY NECESSARY

ADDRESS

NAME OF RESPONSIBLE PARTY LAST FIRST M.I.

CITY, STATE, ZIP | GROUP/FILE NO.

BILL TO ADDRESS

POLICY/SUBSCRIBER NO.

CITY, STATE, ZIP | PHONE NO. | MEDICARE NO. | MEDICAID NO.

Indicate (X) Specimen Type ☐ Fasting ☐ Non-Fasting

☐ Serum - SST ☐ Plasma-Li Heparin ☐ Urine-random ☐ CSF

☐ Serum-red top ☐ Plasma-Na Citrate ☐ Urine – 24 hr _____ mL ☐ Other _____

☐ Plasma-EDTA ☐ Urine-timed _____ hrs

Signed ABN on file at MD's office or ordering facility?

☐ YES ☐ NO

ABN collected at ML? ☐ YES ☐ NO

Face Part 1 - 12" x 11" - vertical perf at 0.5" and 9.5" from the left

MERITER LAB COPY

817698 (Rev. 06/15)

NOTE: "BILL TO" MUST BE CHECKED AT TIME OF COLLECTION. IF NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED

Label affixed to Part 1

A275001 ACCT.NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT.NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT.NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT.NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT.NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT.NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

Apply labels to specimens and remove this portion

IMPORTANT INSTRUCTIONS

WHEN CHECKING BOXES, PLEASE USE AN "X" RATHER THAN A ✔ OR A SLASH.

I.E. = ☒ AMYLASE

Patient Glucose Meter/Laboratory Correlation

UnityPoint-Meriter Laboratories
36 S. Brooks St.
Madison WI 53715

Patient Information:
(chip or Lab label)

Patient Glucose Meter/Laboratory Correlation

Instructions for Clinic/Floor:

1. Order Epic **test 492073.**
2. **Patient should not have eaten, dosed or been given insulin within 2 hours of this test being performed.**
3. Inpatient orders will be drawn by Inpatient Phlebotomy in the patient's room.
4. All other patients should be sent to 2 Center Lab with an OB chart label for patient identification.

Instructions for Phlebotomy staff:

1. LIS will print two labels for "GLMTR" test. Phlebotomy staff will then fill out a Glucose Meter Correlation Sheet and attach one of the SOFT labels to the area in the upper right hand corner of the form.
2. Collect one Lithium Heparin plasma blood specimen.
3. Direct the patient to immediately (within 5 minutes of lab draw) perform a glucose test using their **personal** blood glucose meter.
4. Fill in the patient fingerstick glucose result from their **personal** blood glucose meter on the form while still with the patient.
5. Mark test as collected in the lab computer.
6. Send the Lithium Heparin tube along with this paperwork to the laboratory

Test Information: (*Phlebotomist staff- fill out)*

ML Order Number:_____**(or put on small sticker of lab label)**

Collection Date: _____

Collection Time: _____

*****Patients Meter Result:*** _____