All new Lab orders should be faxed to (912) 819-7265.

Client Name/Address				Referring Physician
	St. Joseph's/Candler **Laboratory Outreach Services**			
	Chatham Pathology Associates Phone: 912.819.8440			
	Fax for lab orders - all locations 912.819.7265			
	Fax for add-on orders or supply requests 912.819.6906			
Patient Name		DOB	SS#	
Collection Date	Collection Time	Gender	Billing ☐ Clie ☐	Insurance
Patient Address		Insurance (Attach copy of card and ID)		
City State Zip		Policy #	Group #	Payer ID #
Telephone		Diagnosis Information (ICD)		

Clinical:		**Cytology GYN:**
___ Comprehensive Metabolic Panel (CMP) GG GT		___ Liquid Based PAP Test (Thin Prep)
___ Basic Metabolic Panel (BMP) GT		___ with High Risk HPV Co-Test (includes 16,18)
___ General Health Panel (GHP) GT&L		___ with High Risk HPV when ASCUS (includes 16,18)
___ Hepatic Function Panel (LIVER) GT		___ Chlamydia/Neisseria Gonorrhea
___ Hepatitis A,B,C Panel (HEP) GT		___ High Risk HPV (includes 16,18)
___ Lipid Panel (LIPID) GT		**Required Information for PAP:** Source ___ Cervical ___ Vaginal Only
___ Prenatal Profile (PRENATAL) GT, L, B		Date LMP: _____
___ Renal Function Panel (RENAL) GT		Previous Abnormal Cytology/Tissue ___ yes ___ no
___ CBC L	___ PTT B	If yes, date: _____
___ Ferritin GT	___ RF GT	**Check All that apply:** ___ Pregnant ___ Abnormal Bleeding
___ Folate, RBC L	___ Sed Rate (ESR) L	___ Hysterectomy ___ Postmenopausal ___ Hormones
___ Folate, serum GT	___ Syphilis Ab GT	___ Postpartum Additional Info:
___ HCG quant GT	___ T3 Uptake GT	**Cytology: Fluid** Source_____ Urine Voided Cath
___ HgB, A1C L	___ T3, Total GT	**Microbiology:** ___ GI panel
___ HIV ½ L	___ T4 GT	___ Urine Culture source: CC Cath
___ Iron GT	___ T4, Free GT	___ Strep Screen, group A (throat)
___ Iron & TIBC (Binding	___ TSH GT	___ Strep Screen, group B (vaginal)
___ Magnesium GT	___ Uric Acid GT	___ Bacterial, aerobic Source_____
___ Microalbumin Urine	___ Urinalysis U	___ Bacterial, anaerobic Source_____
___ PSA GT	___ Vitamin B12 GT	___ AFB Source:_____
___ PT/INR B	___ Vitamin D 25-OH GT	___ Fungus Source _____

Tissue for Pathology:	
Time in formalin: _____	
Specimen	Diagnosis
A.	
B.	
C.	
D.	
Comments, Custom Orders, Additional Tests	
v.100821	

By signing below, I agree to the following:

I understand that St. Joseph's/Candler and its employees, representatives and agents ("SJ/C") provide services and facilities needed for my care and treatment and hereby grant SJ/C my consent for these services upon request and order of my physician(s). I further agree and consent to the use and disclosure of my identifiable information, including any medical information, for the purpose of treatment, payment and/or healthcare operations.

I hereby request that SJ/C collect and perform the tests and services requested by my physician(s). I understand that my insurance provider may require the use of a laboratory other than SJ/C and that this service may not be covered by my insurance provider. If this service is not covered by my insurance provider, I understand that I will be personally billed for this service.

Patient/Authorized Person Signature: _____

Relationship to patient: _____