TriHealth Laboratory Services

New Test Request Form

TriHealth Laboratories

Requesting Physician: _____

Hospital Department: _____

Email: _____ Phone: _____

****TO BE COMPLETED BY THE REQUESTING PHYSICIAN****

Test Name: _____

Preferred Reference Lab (if applicable): _____

Test Description: _____

Test Methodology: _____

Anticipated Number of Tests used per month/year: _____

Test Utilization: ☐ Inpatient ☐ Outpatient ☐ Emergency Department

If utilization is hospital in-patient please explain how these results will influence the treatment plan during current admission

If this test is replacing an existing standard approach to care, please explain:

***Requests for alternative tests that are either available in-house or through existing approved referral laboratories require clinical and analytical data explaining why one method is better than the other ***

How will the results of this test improve patient outcome or management?

What is the evidence-based clinical justification for this test?

REQUESTING DEPARTMENT CHAIR APPROVAL

Signature: _____ Date: _____

Print Name: _____

Submit completed forms to Brittany_Bedel@trihealth.com

****TO BE COMPLETED BY LAB PERSONNEL****

estimated cost/reimbursement
cost/price
alternate reference labs
cpt

Is this test available at one of Th's contracted reference labs?

sent to interfaced?