REQUEST TO SET UP RESEARCH STUDY, 2019-2020

Whenever possible, the ZSFG Clinical Laboratory will honor requests in connection with research projects for tests that we perform, provided that the requested services do not interfere with our primary responsibility of clinical testing for patient care. In order to process your request and determine pricing, we will need the following information:

Today's date: _____

Principal Investigator: _____ Physician's ID Number: _____

Name of Study: _____

Contact person: _____ Title: _____

Mailing address: _____ Telephone #: _____

Email address: _____ FAX #: _____

Emergency telephone or beeper number (24 hours): _____
(Required)

CHR or other IRB Approval Number: _____
(Required)

Have you completed the ZSFG Protocol Application? _____Yes _____ No (Form is available for download at website https://sfgh.ucsf.edu/protocol-applications-zsfg - Please return the form to ZSFG Dean's Office)

COA:

Fund	Dep ID	Project ID	Activity Period	Function	Flex
_ _ _ _	_ _ _ _ _ _	_ _ _ _ _ _ _	_ _	_ _	_ _ _ _

Does this account/contract involve federal funding? _____Yes _____ No

Account Name: _____ Department: _____

Project starting Date: _____ Ending Date: _____

Study participants (please check one): Inpatient _____ Outpatient _____ Animal _____

Billing Contact: _____ Telephone: _____ Email: _____

PLEASE USE THE ATTACHED "RESEARCH TESTS ORDER FORM" TO LIST TESTS NEEDED.

Your **four-letter study C O D E,** for billing: _____ _____ _____ _____
(Use letters only. You will be notified immediately if the code you have selected cannot be used.)

_____
Study Contact Signature

Please complete this form and the "Research Study - Test Order Form" and return both forms to:

Barbara Haller, MD, PhD
Director, ZSFG Clinical Laboratory
Bldg 5, Rm 2M14
FAX: 628-206-3045

For more information, refer to the Clinical Laboratory Manual (on-line at http://labmed.ucsf.edu/sfghlab/), or call the Director's office at x68588.

DO NOT WRITE BELOW THIS LINE

DIVISION APPROVALS

Chemistry _____ Blood Bank _____
Hematology _____ Microbiology _____
LIS _____ Specimen Processing _____

RESEARCH STUDY – TEST ORDER FORM
2019-2020

√	CPT code	TEST NAME	PRICE	√	CPT code	TEST NAME	PRICE
	82040	ALBUMIN	$11.75		87389	HIV 1/2 ANTIGEN/ANTIBODY COMBO	$26.00
	82042	ALBUMIN (CSF) (Sendout, incl handling fee)	$13.70		86701/02	HIV 1/2 Antibody Differentiation	$66.50
	82105	ALPHA-FETOPROTEIN (TUMOR)	$17.50		82784	IGG	$16.25
	84075	ALKALINE PHOSPHATASE, BLOOD	$11.75		83525	INSULIN, BLOOD	$17.50
	84460	ALT (TRANSFERASE, ALANINE AMINO)	$11.75		83540	IRON, SERUM	$11.75
	84450	AST (TRANSFERASE, ASPARTATE AMINO)	$11.75		83605	LACTATE (STAT; incl Stat charge)	$38.75
	82248	BILIRUBIN, BLOOD, DIRECT	$11.75		83615	LD (LACTIC DEHYDROGENASE)	$11.75
	82247	BILIRUBIN, BLOOD, TOTAL	$11.75		83690	LIPASE	$12.00
	82803	BLOOD GAS PANEL (STAT; incl Stat charge)	$42.75		80061	LIPID PANEL	$14.00
	84520	BUN (UREA NITROGEN, QUANT)	$11.75		80076	LIVER PANEL	$14.50
	82310	CALCIUM	$11.75		83735	MAGNESIUM, BLOOD	$11.75
	82340	CALCIUM, URINE	$13.50		80048	METABOLIC PANEL, Basic	$14.00
	85027	CBC, PLATELETS	$16.50		80053	METABOLIC PANEL, Comprehensive	$15.00
	85025	CBC, PLATELETS & DIFF. (AUTOMATED)	$16.50			METABOLIC PANEL, Comp + CSC*	$17.00
	86361	CD3 FLOW CYTOMETRY	$44.00		82043	MICROALBUMIN, URINE	$12.50
	86361	CD4 FLOW CYTOMETRY	$44.00		83930	OSMOLALITY, SERUM	$14.00
	86360	CD4/CD8 FLOW CYTOMETRY	$44.00		83935	OSMOLALITY, URINE	$14.00
	89051	CELL COUNT, CSF (STAT; incl Stat charge)	$78.75		83970	PARATHYROID HORMONE, INTACT	$17.75
	82465	CHOLESTEROL, TOTAL	$11.75		87530	PARTIAL THROMBOPLASTIN TIME	$27.00
	82565	CREATININE	$11.75		80185	PHENYTOIN (DILANTIN)	$14.50
	82575	CREATININE CLEARANCE, URINE	$13.75		84100	PHOSPHATE	$11.75
	82550	CREATININE KINASE (CK, CPK), TOTAL	$11.75		84105	PHOSPHATE (URINE)	$13.50
	82570	CREATININE, URINE	$13.50		84132	POTASSIUM	$11.75
	86141	CRP, HIGH SENSITIVITY	$15.50		84133	POTASSIUM, URINE	$13.50
	87040	CULT., BLOOD, AEROBIC	$38.25		84134	PREALBUMIN	$16.25
	87070	CULT., CSF	$34.25		81025	PREGNANCY TEST, URINE	$19.00
	87070	CULT., MISC.	$51.00		84157	PROTEIN, CSF	$12.50
	87070	CULT., RESPIRATORY	$57.75		84157	PROTEIN, BODY FLUID	$11.75
	G0434	DRUGS OF ABUSE SCREEN, CONFIRMATION	$68.00		84155	PROTEIN, SERUM (TOTAL)	$11.75
	G0431	DRUGS OF ABUSE SCREEN (DAU)	$25.50		84156	PROTEIN, URINE	$14.25
	80051	ELECTROLYTES	$13.75		85610	PROTHROMBIN TIME	$27.00
	G6040	ETHANOL, SERUM	$12.25		86592	RPR	$13.50
	82728	FERRITIN	$16.25		86593	RPR TITER	$28.00
	82947	GLUCOSE, CSF	$11.75		85651	SEDIMENTATION RATE	$27.50
	82947	GLUCOSE, EXCEPT URINE	$11.75		84295	SODIUM, SERUM	$11.75
	82977	GLUTAMYLTRANSFERASE, GAMMA (GGT)	$11.75		84300	SODIUM, URINE	$13.50
	87205	GRAM STAIN	$19.50		87184	SUSCEPTIBILITY, KB	$26.00
	84702	HCG, QUANT	$16.25		87186	SUSCEPTIBILITY, MIC	$21.00
	83718	HDL-CHOLESTEROL	$12.00		84403	TESTOSTERONE, BLOOD	$16.50
	83036	HEMOGLOBIN A1C , DIRECT (GLYCATED HGB)	$31.00		G0434	THC, URINE	$12.00
	86709	HEPATITIS A ANTIBODY, IGM	$18.25		87680	TP-PA (SYPHILIS CONFIRMATION)	$33.75
	86708	HEPATITIS A ANTIBODY, TOTAL	$16.00		84466	TRANSFERRIN	$14.00
	86705	HEPATITIS B CORE, IGM	$18.25		84478	TRIGLYCERIDES, BLOOD	$11.75
	86704	HEPATITIS B CORE AB, TOTAL	$16.00		84484	TROPONIN	$16.00
	86706	HEPATITIS B SURFACE AB	$15.50		84540	UREA NITROGEN, URINE	$13.50
	87340	HEPATITIS B SURFACE ANTIGEN	$14.50		84550	URIC ACID, BLOOD	$11.75
	87341	HEPATITIS B SURFACE ANTIGEN CONFIRMATION	$23.25		84560	URIC ACID, URINE	$13.50
	87517	HEPATITIS B VIRAL LOAD	$81.75		81000/01	URINALYSIS MICROSCOPY & DIPSTICK	$23.75
	86803	HEPATITIS C ANTIBODY	$17.50		81003	URINALYSIS,W/O MICRO, AUTO. (Dipstick)	$16.00
	87522	HEPATITIS C VIRAL LOAD	$93.50		82306	VITAMIN D, 25-OH	$20.50
	87536	HIV VIRAL LOAD, RT-PCR	$86.75				
						*CSC = CHOL, LD, PO4, TRIG, URIC ACID, HDL, LDL	

RESEARCH STUDY – TEST ORDER FORM
2019-2020

Please note that there is a $25 surcharge added to the price of each test or test panel for STAT service. Some tests may not be available on a stat basis.

List any other test(s) needed for your study: _____
_____
_____

Please provide the following **required** information regarding testing volume:

Number of patients enrolled? _____ How often will patients be drawn for testing? _____

How many samples will be submitted per week (approx.)? _____

Special handling required? No ☐

Yes ☐ Centrifuge and Hold at Specified Temperature, $19.25 per Specimen

Yes ☐ Other, please describe (Note: Additional charge for special handling to be determined)

_____

Results Reporting:

Special reports required? No ☐ Yes ☐
If yes, please describe (Please note: There is an additional charge for special reports.)

_____
_____

Results in EPIC/EMR? No ☐ Yes ☐
If yes, the patient's name and medical record number must be provided. Please inform your patients that these research study results will be available in the electronic and paper Medical Records.

Do you currently have a special mail slot in 2M (pick-up location) for your reports? No ☐ Yes ☐

If yes, please list your four-letter CODE _____.

Do you need a mail slot in 2M for this study? No ☐ Yes ☐

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