



ORDER FOR OUTPATIENT LABORATORY SERVICES
To Schedule call 858-4090
Fax to 350-3862

Appt date/time

Facility where service to be provided: _____

Patient full name(Last, first, middle initial) _____ **DOB** ____/____/____

Signs and symptoms: _____ **SS#:** ____ - ____ - ____

ICD9 required _____ **Gender** M _____ F _____

Independent Practitioner-MD/DO, PA, ARNP(printed name) _____

Independent Practitioner signature(no stamped signature) _____ **Date & time order written** ____/____/____

Requisition completed by: _____ **Date & time order written** ____/____/____

Comments or special instructions: _____

STAT **Call results to** _____ **Fax results to** _____

Reoccurring orders:		Start date: _____	Stop Date: _____
Daily _____		Monthly _____	
Weekly _____		Other _____	
Biweekly _____			
Comprehensive Panel Albumin, Bilirubin Total, Calcium, Chloride, Creatinine, Glucose, Alk Phosphatase, Potassium, Total Protein, Sodium, ALT, BUN, AST, CO2	Basic Metabolic CO2, Chloride, Creatinine, Glucose, Potassium, Sodium, Bun, Calcium	Hepatic Panel Albumin, Bilirubin Total & Direct, Alkaline Phosphatase, AST, ALT, Total Protein	Lipid Panel Cholesterol, HDL Cholesterol, Triglyceride, CHD Risk ratio, Calculated LDL and VLDL
Renal Panel Sodium, Potassium, Chloride, CO2, BUN, Calcium, Creatinine, Glucose, Albumin, Phosphorus	Hepatitis Panel Hep B core Antibody IGM, Hep B Surface Antigen, Hep A Antibody IGM, Hep C Total Antibody	Electrolyte Panel CO2, Chloride, Potassium, Sodium	BY APPOINTMENT ONLY
ALBUMIN	Hemoglobin/Hematocrit	URIC ACID	
ALT-SGPT	INSULIN	URINALYSIS includes culture if WBC > 5	Lactose Tolerance ____hr
AMYLASE	IRON SERUM	XTREC	Sweat Chloride
ANA SCREEN AND QUANT	IRON PANEL Iron TIBC % sat, Trans	Protein Total Urine 24hr	
AST/SGOT	LIPASE	Protein/Creat Ratio Urine	
BILIRUBIN	PHOSPHORUS	Creatinine Clearance Urine 24hr	OTHER:
BILIRUBIN T&D	POTASSIUM	HT: _____	OTHER:
B-Type Natriuretic Peptide	PREALBUMIN	WT: _____	OTHER:
BUN	Pregnancy HCG quant		MICROBIOLOGY
C REACTIVE PROTEIN	Pregnancy Test (screen)	BLOOD BANK	SOURCE REQUIRED:
CALCIUM	PROGRAF (FK-506)	TYPE & SCREEN	
CBC W/DIFFERENTIAL	PROTEIN, TOTAL	TYPE & CROSSMATCH	Fungal culture/smear
CBC NO DIFFERENTIAL	PROTIME	ABO/Rh	AFB culture/smear
CHOLESTEROL	PSA	RED CELLS (#UNITS): _____	Urine culture*
CREATININE	PTT	IRRADIATED	Stool culture
CYCLOSPORINE whole blood	RA FACTOR	PLATELET PHERESIS	Ova parasite
DIGOXIN	SED RATE	FP (#UNITS): _____	Rapid Antigen, Grp A Strep
DILANTIN	SODIUM	OTHER:	Respiratory Viral Panel (RVP)
GLUCOSE	TACROLIMUS (Prograf)	OTHER:	Routine/culture smear*
HEMOGLOBIN A1C	TSH w/reflex Free T4	OTHER:	* Identification and/or susceptibilities will be performed on all significant pathogens

VC3742 06/11

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