Via Christi HEALTH

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**_____

Reoccuring 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	☐	Glucose Tolerance_____hr
☐	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	

VC3718 06/11

Via Christi Hospitals

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