

LABORATORY OUTREACH REQUISITION

Bill to:	<input type="checkbox"/> Client	<input type="checkbox"/> Call Results to:
	<input type="checkbox"/> Insurance	<input type="checkbox"/> Fax Results to:
	<input type="checkbox"/> Patient	<input type="checkbox"/> Copy Results to:

PATIENT INFORMATION			INSURANCE BILLING INFORMATION		
Pt Last Name	First	M I	Primary	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
Address	Birth Date	Sex M F	Subscriber Last Name	First	M I
City	Home Phone		Beneficiary/Member #	Group #	
ST	ZIP		Claims Address	City	ST ZIP
CLIENT INFORMATION - REFERRING PHYSICIAN SIGNATURE			Secondary	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
			Subscriber Last Name	First	M I
			Beneficiary/Member #	Group #	
			Claims Address	City	ST ZIP
			COLLECTION / REPORTING INFORMATION		
Today's Date/Time:			To be done within:	<input type="checkbox"/> 6 mo.	<input type="checkbox"/> 12 mo.

All requests for Laboratory testing must be submitted with valid diagnosis information to support medical necessity of all tests ordered. Medicare generally does not cover routine screening tests. Specific diagnosis and frequency criteria apply to the Medicare coverage of preventative screening procedures.

Diagnosis:

CHEMISTRY PANELS (* Fasting Recommended)	CHEMISTRY (continued)	MICROBIOLOGY - must indicate source
<input type="checkbox"/> Basic Metabolic Panel * <input type="checkbox"/> Comprehensive Metabolic Panel * <input type="checkbox"/> Electrolyte Panel <input type="checkbox"/> Hepatitis Acute Panel <input type="checkbox"/> Lipid Panel * <input type="checkbox"/> Liver Function Panel (Hepatic) <input type="checkbox"/> Renal Function Panel * MEDICARE SCREENING (ABN REQ.) <input type="checkbox"/> Lipid Panel (Cardiovascular Screen) Freq. - Covered every 5 years DX - Z13.6 Encnter for screening cardiovascular disorders <input type="checkbox"/> Prostate Specific Antigen, Screening (PSA) Freq. - Covered Annually DX - Z12.5 Encounter for scrn for malign. neoplasm of prost <input type="checkbox"/> Diabetic Screening- Dx - Z13.1 •Fasting glucose and 2 hr. post-glucose Freq. - Individual w/ pre-diabetes - twice yearly Individual w/o diag. pre-diabetes - once yearly	<input type="checkbox"/> PSA Screening <input type="checkbox"/> PSA Diagnostic <input type="checkbox"/> T3 Free (Triiodothyronine Free) <input type="checkbox"/> T3 Total (Triiodothyronine Total) <input type="checkbox"/> T4 Free (Thyroxine Free) <input type="checkbox"/> T4 Total (Thyroxine Total) <input type="checkbox"/> Testosterone, Total - UVM <input type="checkbox"/> Testosterone, Total & Free - Mayo <input type="checkbox"/> Thyroid (TSH) Cascade <input type="checkbox"/> TSH <input type="checkbox"/> Uric Acid <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> Vitamin D Total (25 Hydroxy) DRUGS <input type="checkbox"/> Digoxin <input type="checkbox"/> Lithium <input type="checkbox"/> Phenytoin (Dilantin®) <input type="checkbox"/> Valproic Acid (Depakene®)	Please indicate source/site: <input type="checkbox"/> Blood Culture <input type="checkbox"/> Fungus Culture - skin / hair / nails <input type="checkbox"/> GTY Probe (Vaginal Pathogens) <input type="checkbox"/> Rapid Strep A Antigen (throat) <input type="checkbox"/> Sputum Culture <input type="checkbox"/> Strep A (throat) culture <input type="checkbox"/> Group B Strep PCR <input type="checkbox"/> Wound Culture MOLECULAR MICRO - must indicate source Please indicate source/site: <input type="checkbox"/> Chlamydia DNA PCR (CT) <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Gonococcus DNA PCR (NG) <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Influenza A/B and RSV PCR <input type="checkbox"/> SARS CoV2 PCR (COVID-19) <input type="checkbox"/> Upper Respiratory Panel STOOL TESTS <input type="checkbox"/> GI Pathogen PCR <input type="checkbox"/> Lactoferrin (Stool WBC) <input type="checkbox"/> Ova and Parasites - UVMCM <input type="checkbox"/> Annual Screen Occult Blood Feces <input type="checkbox"/> Diagnostic Occult Blood Feces <input type="checkbox"/> Clostridioides difficile PCR <input type="checkbox"/> H pylori + Clarithro Resist, PCR, F-Mayo OTHER TESTS
HEMATOLOGY	BLOOD BANK	
<input type="checkbox"/> Complete Blood Count (CBC) <input type="checkbox"/> CBC auto diff/rflx manual diff <input type="checkbox"/> Hemoglobin & Hematocrit <input type="checkbox"/> Sed Rate	<input type="checkbox"/> ABO/Rh Type <input type="checkbox"/> Antibody Screen <input type="checkbox"/> Direct Antiglobulin Test	
COAGULATION	SEROLOGY-IMMUNOLOGY	
<input type="checkbox"/> PT/INR <input type="checkbox"/> PTT	<input type="checkbox"/> ANA (Antinuclear Ab Screen) - Mayo <input type="checkbox"/> Celiac Disease Serology Cascade - Mayo <input type="checkbox"/> FibroTest-ActiTest, S-Mayo <input type="checkbox"/> HCV Genotype, S-Mayo <input type="checkbox"/> Hepatitis A Total Antibody (IgG) <input type="checkbox"/> Hepatitis B Core Total (IgM/IgG) <input type="checkbox"/> Hepatitis B Surface Antibody (IgG) <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis C Antibody <input type="checkbox"/> Hepatitis C Virus RNA Detect Quant-UVM <input type="checkbox"/> HIV 1/2 Antibody and p24 Antigen <input type="checkbox"/> Lyme Disease Serology <input type="checkbox"/> Measles IgG <input type="checkbox"/> Mononucleosis screen <input type="checkbox"/> Mumps IgG <input type="checkbox"/> Rheumatoid Factor <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Thyroid Abs - UVM <input type="checkbox"/> Ehrlichia Chaffeensis (HME) Ab S-Mayo <input type="checkbox"/> Anaplasma phagocytophilum Ab S-Mayo <input type="checkbox"/> Babesia microti Ab S-Mayo <input type="checkbox"/> Varicella IgG	
CHEMISTRY	URINE TESTS	
<input type="checkbox"/> ALT/SGPT <input type="checkbox"/> Amylase <input type="checkbox"/> AST/SGOT <input type="checkbox"/> Bilirubin, Direct <input type="checkbox"/> Bilirubin, Total <input type="checkbox"/> BUN <input type="checkbox"/> CA 125 <input type="checkbox"/> Calcium, Total <input type="checkbox"/> Creatinine <input type="checkbox"/> CRP (C-Reactive Protein) <input type="checkbox"/> Diabetes, Gestational Screen, non-fasting •1 hr. post-glucose, non-fasting <input type="checkbox"/> Ferritin <input type="checkbox"/> Folate, Serum <input type="checkbox"/> Follicle Stim. Hormone (FSH) <input type="checkbox"/> GGT <input type="checkbox"/> Glucose, Fasting Level <input type="checkbox"/> HCG Quantitative <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> hsCRP(High Sensitivity) <input type="checkbox"/> Iron <input type="checkbox"/> Iron Binding Capacity (includes Iron) <input type="checkbox"/> Lipase <input type="checkbox"/> Magnesium <input type="checkbox"/> NT-proBNP <input type="checkbox"/> PTH (Parathyroid Hormone, Intact) <input type="checkbox"/> Phosphorus <input type="checkbox"/> Potassium <input type="checkbox"/> Syphilis Ab	<input type="checkbox"/> Microalbumin Level Urine <input type="checkbox"/> Urinalysis (UA w/ microscopic if indicated) <input type="checkbox"/> Culture & Sensitivity (if indicated) <input type="checkbox"/> Urine Culture <input type="checkbox"/> Urine Cytology (Path Non-Gyn) <input type="checkbox"/> Voided <input type="checkbox"/> Cath spec	
Requisition Quality Check		
Receptionist		
Phlebotomist		
Processor		

RRMC Patient Label

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ADDITIONAL TESTING AT ADDITIONAL CHARGES WILL BE DONE IF CERTAIN CRITERIA ARE MET

1. **CBC** - if platelets < 50 reflexes to Immature Platelet Fraction; reflex manual diff if indicated, reflex manual diff & path review if indicated
2. **CBC with auto diff** - reflex manual diff if indicated, if platelets < 50 reflexes to Immature Platelet Fraction; reflex manual diff & path review if indicated
3. **Celiac Disease Serology Cascade** -If IgA is age-specified normal, then tissue transglutaminase (tTG) IgA will be performed. If tTG IgA is equivocal, then endomysial antibodies IgA and deamidated gliadin antibody IgA will be performed. If IgA is greater or equal to 1.0 mg/dL, but lower than age-specified normal, then tTG IgA, tTG IgG, deamidated gliadin IgA, and deamidated gliadin IgG will be performed. If IgA is below detection (<1.0 mg/dL), then tTG IgG and deamidated gliadin IgG will be performed.
4. **Hepatitis A Antibody** - if positive, Hepatitis A IgM Antibody performed
5. **Hepatitis C Antibody** - if reactive, Hep C RNA performed
6. **HIV 1/2 Antibody and p24 Antigen** - if indicated reflexes to HIV 1/2 Ab Differentiation
7. **Lipid Profile**- greater than 400 trig. - will perform measured LDL-fasting required
8. **Lyme Serology** - if positive or equivocal , Western Immunoblot performed
9. **Rapid Strep A Antigen (throat)** - if negative, reflexes to Strep A (throat) culture
10. **Syphilis AB** - If the Syphilis Ab is reactive or equivocal a Syphilis Total Ab w/ Reflex , S will be performed. If the syphilis total antibody result is reactive or equivocal, then the rapid plasma reagin (RPR) screen will be performed. If the RPR screen is reactive, then the RPR titer will be performed. If the RPR screen is nonreactive, then syphilis antibody Treponema pallidum particle agglutination testing will be performed.
11. **TSH Cascade** - if TSH is low, then free T4 will be performed. If the FT4 is normal or low with a TSH of 0.1IU/ml, then T3 total will be performed. If FT4 is high, the cascade is complete. If TSH is high, then FT4 will be performed.
12. **Urinalysis with reflex microscopic** - reflexes to microscopic
13. **Urinalysis with reflex microscopic with culture if indicated** - reflexes to microscopic and a culture if indicated

COMPONENTS INCLUDED IN PANEL TEST

Organ or disease-related panels should only be ordered when all components are deemed medically necessary.

* Fasting Recommended

1. **Basic Metabolic Panel *** - Glucose, BUN, Creatinine, Carbon Dioxide, Chloride, Potassium, Sodium, Calcium
2. **Comprehensive Metabolic Panel *** - Glucose, BUN, Calcium, Carbon Dioxide, Chloride, Potassium, Sodium, Total Protein, Albumin, Total Bilirubin, AST, ALT, Alkaline
3. **Electrolytes Panel** - Carbon Dioxide, Chloride, Potassium, Sodium
4. **GI Pathogen PCR**- Campylobacter species, Salmonella species, Shigella species, Vibrio species (V. cholera and V. parahaemolyticus), Yersinia enterocolitica, Norovirus (GI and GII), Rotavirus, Shiga Toxin 1 and Shiga Toxin 2, Cryptosporidium, Adenovirus F40/41, Astrovirus, Cyclospora cayetanensis, Entamoeba histolytica, Plesiomonas shigelloides, Giardia lamblia, Sapovirus (I, II, IV, and V), Enteroggregative E. coli (EAEC), Enteropathogenic E. coli (EPEC), and Enterotoxigenic E. coli (ETEC) lt/st
5. **Hepatitis Acute Panel** - Hepatitis A IgM, Hepatitis B Surface Antigen, Hepatitis B Core IgM, Hepatitis C Antibody
6. **Liver Function Panel (Hepatic)** - AST, ALT, Total Bilirubin, Direct Bilirubin, Alkaline Phosphatase, Albumin, Total protein
7. **Lipid Profile *** - Cholesterol, Triglycerides, VLDL, HDL (includes calculated LDL)
8. **Renal Function Panel *** - Albumin, Calcium, Carbon Dioxide, Chloride, Potassium, Sodium, Creatinine, Glucose, Phosphorous, BUN
10. **Upper Respiratory Panel** - Adenovirus, Coronaviruses (229E, OC43, HKU1, and NL63), Human Metapneumovirus, Influenza A (H1, H1-2009, and H3) and Influenza B, Parainfluenza Viruses (1-4), Respiratory Syncytial Virus (RSV), Rhinoviruses/Enteroviruses (unable to differentiate), Bordetella pertussis, Bordetella parapertussis, Chlamydia pneumoniae, and Mycoplasma pneumoniae are all targets potentially detected from the nasopharyngeal swab taken from individuals suspected of respiratory tract infections.

BILLING

We will submit a claim for hospital-related charges to your insurance, if appropriate, and send you a bill for any amount not covered by your insurance.

Please Note: Some test procedures may be reviewed by a physician who is not employed by Rutland Regional. In these instances, you may receive a separate bill from that physician for their interpretation time. If you have questions about your bill, call 802.747.1751 or toll free 1.866.460.8277.

OUTPATIENT LABORATORY HOURS

Fax requisition -747.6200

Please visit bit.ly/BloodDraw2020 or call 802.747.1771

