

NURSING HOME REQUISITION

Facility	
<input type="checkbox"/> Rutland Heath & Rehab	<input type="checkbox"/> Genesis - MVC
<input type="checkbox"/> The Pines	<input type="checkbox"/> The Meadows
<input type="checkbox"/> St Joseph Kervick	Floor/Unit: _____
<input type="checkbox"/> Other	

PATIENT INFORMATION			INSURANCE BILLING INFORMATION			
Patient Last Name	First	M I	Medicare Patient is: <input type="checkbox"/> Level 1 (bill nursing home) <input type="checkbox"/> Not Level 1 (complete insurance info)			
Address	Birth Date	Sex M F X	Primary	<input type="checkbox"/> Medicare <input type="checkbox"/> Self	<input type="checkbox"/> Medicaid <input type="checkbox"/> Spouse	<input type="checkbox"/> Other <input type="checkbox"/> Child
City	Home Phone		Subscriber Last Name	First	M I	
ST	ZIP		Beneficiary/Member #	Group #		

CLIENT INFORMATION - REFERRING PROVIDER			Claims Address			City	ST	ZIP
Provider First & Last Name Printed:			Secondary			<input type="checkbox"/> Medicare <input type="checkbox"/> Self	<input type="checkbox"/> Medicaid <input type="checkbox"/> Spouse	<input type="checkbox"/> Other <input type="checkbox"/> Child
Provider Signature:			Subscriber Last Name	First	M I			
Date: _____ Time: _____			Beneficiary/Member #	Group #				

COLLECTION / REPORTING INFORMATION			Claims Address			City	ST	ZIP
To be done within: <input type="checkbox"/> STAT <input type="checkbox"/> Fasting								

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/ICD10:

<input type="checkbox"/> Call Results to:	<input type="checkbox"/> Copy Results to: (Provider First & Last Name)
	<input type="checkbox"/> Copy Results to: (Provider First & Last Name)
<input type="checkbox"/> Fax Results to:	<input type="checkbox"/> Copy Results to: (Provider First & Last Name)
	<input type="checkbox"/> Copy Results to: (Provider First & Last Name)

CHEMISTRY PANELS	CHEMISTRY	MICROBIOLOGY - must indicate source
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|--|---|---|
| <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 (Fasting)
<input type="checkbox"/> Liver Function Panel (Hepatic)
<input type="checkbox"/> Renal Function Panel
MEDICARE SCREENING (ABN REQ.)
<input type="checkbox"/> Cardiovascular Screen (Lipid Panel)
Freq. - Covered every 5 years
DX - Z13.6 Encounter for screening for cardiovascular disorders | <input type="checkbox"/> BUN
<input type="checkbox"/> Creatinine
<input type="checkbox"/> CRP (C-Reactive Protein)
<input type="checkbox"/> Ferritin
<input type="checkbox"/> Folate Level, Serum
<input type="checkbox"/> Glucose, Fasting Level
<input type="checkbox"/> Hemoglobin A1c
<input type="checkbox"/> Iron Binding Capacity (includes Iron)
<input type="checkbox"/> Iron Level
<input type="checkbox"/> Magnesium Level
<input type="checkbox"/> NT-proBNP
<input type="checkbox"/> Parathyroid Hormone, Intact (PTH)
<input type="checkbox"/> Phosphorus Level
<input type="checkbox"/> Potassium Level
<input type="checkbox"/> Thyroid (TSH) Cascade
<input type="checkbox"/> TSH
<input type="checkbox"/> T4 free
<input type="checkbox"/> T3, Total (Triiodothyronine Total)
<input type="checkbox"/> T3, Free (Triiodothyronine Total)
<input type="checkbox"/> Uric Acid
<input type="checkbox"/> Vitamin B12 Level
<input type="checkbox"/> Vitamin D Total (25 Hydroxy) | Please indicate source/site:
<input type="checkbox"/> Fungus Culture - skin / hair / nails
<input type="checkbox"/> Wound Culture
<input type="checkbox"/> Anaerobic Culture - anaerobe transp. vial
<input type="checkbox"/> Sputum Culture
<input type="checkbox"/> Blood Culture
<input type="checkbox"/> Rapid Strep A (throat)
<input type="checkbox"/> Strep A (throat) culture
<input type="checkbox"/> Influenza A/B and RSV PCR
<input type="checkbox"/> Coronavirus SARS-COV-2 |
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HEMATOLOGY	STOOL TESTS
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<input type="checkbox"/> CBC (Hemogram) <input type="checkbox"/> CBC diff/rflx manual diff <input type="checkbox"/> Hemoglobin & Hematocrit <input type="checkbox"/> Sed Rate	<input type="checkbox"/> GI Pathogen PCR <input type="checkbox"/> Clostridium Difficile Screen
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COAGULATION	OTHER TESTS
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<input type="checkbox"/> PT/INR <input type="checkbox"/> PTT	
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DRUGS	URINE TESTS
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<input type="checkbox"/> Digoxin <input type="checkbox"/> Lithium Level <input type="checkbox"/> Phenytoin (Dilantin®) Level <input type="checkbox"/> Valproic Acid (Depakene®) Level	<input type="checkbox"/> Microalbumin Level Urine <input type="checkbox"/> Urinalysis (UA w/ microscopic if ind.) <input type="checkbox"/> Culture & Sensitivity (if indicated) <input type="checkbox"/> Urine Culture
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BLOOD BANK <input type="checkbox"/> ABO/Rh Type	Requisition Quality Check Receptionist _____ Phlebotomist _____ Processor _____	RRM Patient Label
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LABORATORY NURSING HOME REQUISITION

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

CBC (Hemogram) - if platelets < 50 reflexes to Immature Platelet Fraction

CBC with auto diff - reflex manual diff if indicated, if platelets < 50 reflexes to Immature Platelet Fraction

Lipid Profile- greater than 400 trig. - will perform measured LDL-fasting required

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.

Urinalysis with reflex microscopic - reflexes to microscopic

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.

Basic Metabolic Panel - Glucose, BUN, Creatinine, Electrolytes, Calcium

Comprehensive Metabolic Panel - Glucose, BUN, Calcium, Electrolytes, Total Protein, Albumin, Total Bilirubin, AST, ALT, Alkaline

Electrolytes Panel - Carbon dioxide, Chloride, Potassium, Sodium

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), Enteropathogenic E. coli (EPEC), and Enterotoxigenic E. coli (ETEC) It/st

Hepatitis Acute Panel - Hepatitis A IgM, Hepatitis B Surface Antigen, Hepatitis B Core IgM, Hepatitis C Antibody

Liver Function Panel (Hepatic) - AST, ALT, Total Bilirubin, Direct Bilirubin, Alkaline Phosphatase, Albumin, Total protein

Lipid Profile (Fasting required) - Cholesterol, Triglycerides, VLDL, HDL (includes calculated LDL)

Renal Function Panel - Albumin, Calcium, Electrolytes, Creatinine, Glucose, Phosphorous, BUN

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

RRMC Blood Draw Station: Monday - Friday 7:00 am - 6 pm; Saturday 8 am - Noon

