

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

CHEMISTRY PANELS (* Fasting Recommended)	CHEMISTRY (continued)	MICROBIOLOGY - must indicate source
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- ☐ Basic Metabolic Panel *
- ☐ Comprehensive Metabolic Panel *
- ☐ Electrolyte Panel
- ☐ Hepatitis Acute Panel
- ☐ Lipid Panel *
- ☐ Liver Function Panel (Hepatic)
- ☐ Renal Function Panel *

MEDICARE SCREENING (ABN REQ.)

- ☐ Lipid Panel (Cardiovascular Screen)
Freq. - Covered every 5 years
DX - Z13.6 Encnter for screening cardiovascular disorders
Prostate Specific Antigen, Screening
Freq. - Covered Annually
DX - Z12.5 Encounter for scrn for malign. neoplasm of prost
- ☐ 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

- ☐ PSA Screening
- ☐ PSA Diagnostic
- ☐ T3 Free (Triiodothyronine Free)
- ☐ T3 Total (Triiodothyronine Total)
- ☐ T4 Free (Thyroxine Free)
- ☐ T4 Total, S-UVMMC (Thyroxine Total)
- ☐ Testosterone, Total - UVM
- ☐ Testosterone, Total & Free - Mayo
- ☐ Thyroid (TSH) Cascade
- ☐ TSH
- ☐ Uric Acid
- ☐ Vitamin B12
- ☐ Vitamin D Total (25 Hydroxy)

DRUGS

- ☐ Digoxin
- ☐ Lithium
- ☐ Phenytoin (Dilantin®)
- ☐ Valproic Acid (Depakene®)

- Please indicate source/site:
- ☐ Blood Culture
 - ☐ Fungus Culture - skin / hair / nails
 - ☐ Rapid Strep A Antigen (throat)
 - ☐ Sputum Culture
 - ☐ Strep A (throat) culture
 - ☐ Group B Strep PCR
 - ☐ Wound Culture
 - ☐ Varicella Zoster Virus PCR (VZV)
 - ☐ Herpes Simplex Virus 1 & 2 (HSV)
 - ☐ SARS CoV2 Influenza A/B RSV PCR

STI/Urogenital Molecular Testing, NAAT

- ☐ Mycoplasma genitalium
☐ Swab ☐ Urine
- ☐ Neisseria Gonorrhoeae (NG)
☐ Swab ☐ Urine
- ☐ Chlamydia Trachomatis
☐ Swab ☐ Urine
- ☐ Vaginitis Panel
- ☐ Trichomonas Vaginalis- Mayo

STOOL TESTS

- ☐ GI Pathogen PCR
- ☐ Lactoferrin (Stool WBC)
- ☐ Ova and Parasite - Mayo
- ☐ Annual Screen Occult Blood Feces
- ☐ Diagnostic Occult Blood Feces
- ☐ Clostridioides difficile PCR
- ☐ H pylori + Clarithro Resist, PCR, F-Mayo

OTHER TESTS

HEMATOLOGY	BLOOD BANK
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- ☐ Complete Blood Count (CBC)
- ☐ CBC auto diff/rflx manual diff
- ☐ Hemoglobin & Hematocrit
- ☐ Sed Rate
- ☐ ABO/Rh Type
- ☐ Antibody Screen
- ☐ Direct Antiglobulin Test

SEROLOGY-IMMUNOLOGY

- ☐ ANA (Antinuclear Ab Screen) - Mayo
- ☐ Celiac Disease Serology Cascade - Mayo
- ☐ FibroTest-ActiTest, S-Mayo
- ☐ HCV Genotype, S-Mayo
- ☐ Hepatitis A Total Antibody (IgG/IgM)
- ☐ Hepatitis B Core Total (IgM/IgG)
- ☐ Hepatitis B Surface Antibody (IgG)
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis C Antibody
- ☐ Hepatitis C Virus RNA Detect Quant-UV
- ☐ HIV 1/2 Antibody and p24 Antigen
- ☐ Lyme Antibody, S-UVMMC
- ☐ Measles IgG Ab, S-UVMMC
- ☐ Mononucleosis screen
- ☐ Mumps Ab IgG, S-UVMMC
- ☐ Rheumatoid Factor
- ☐ Rubella IgG
- ☐ Thyroid Abs - UVM
- ☐ Ehrlichia Chaffeensis (HME) Ab S-Mayo
- ☐ Anaplasma phagocytophilum Ab S-Mayo
- ☐ Babesia microti Ab S-Mayo
- ☐ Varicella IgG Ab, S-UVMMC

URINE TESTS

- ☐ Microalbumin Level Urine
- ☐ Urinalysis (UA w/ microscopic if indicated)
- ☐ Urinalysis w/ micro + culture (if indicated)
- ☐ Urine Culture
- ☐ Urine Cytology (Path Non-Gyn)
☐ Voided ☐ Cath spec

Requisition Quality Check

Receptionist
Phlebotomist
Processor

White: Lab; Yellow: Provider
Form #4757 Created 05/16 Rev, 5/23, 6/23, 4/24, 9/24, 4/25

RRMC Patient Label

LABORATORY OUTREACH REQUISITION

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), Enteraggregative 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. **Respiratory Quad Panel** - SARS CoV2, Influenza an and B and RSV

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

