

**LABORATORY OUTREACH
REQUISITION**

Bill to: Client Call Results to:
 Insurance Fax Results to:
 Patient Copy Results to:

PATIENT INFORMATION			INSURANCE BILLING INFORMATION		
Pt Last Name	First	MI	Primary Insurance:		
Address	Birth Date	Sex M F	Subscriber Last Name	First	MI
City	Home Phone		Beneficiary/Member #	Group #	
ST	ZIP		Claims Address	City	ST ZIP
			Secondary Insurance:		
			Subscriber Last Name	First	MI
			Beneficiary/Member #	Group #	
			Claims Address	City	ST ZIP

CLIENT INFORMATION - REFERRING PHYSICIAN		
Provider First and Last name (Printed):		
Provider Signature:		
Date and Time:		

COLLECTION / REPORTING INFORMATION
 To be done within: 6 mo. 12 mo. STAT 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: (Required)

CHEMISTRY PANELS (* Fasting Recommended)	Hematology/Coagulation	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 <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"/> Ferritin <input type="checkbox"/> Folate, Serum <input type="checkbox"/> Folicle Stim. Hormone <input type="checkbox"/> GGT <input type="checkbox"/> Glucose Level, Fasting <input type="checkbox"/> Glucose 2 HR screen (non gestational) <input type="checkbox"/> HCG Quantitative <input type="checkbox"/> Hemoglobin A1C <input type="checkbox"/> HS CRP (high sensitivity) <input type="checkbox"/> Iron <input type="checkbox"/> Transferrin <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"/> PSA, Screening (Dx: Z12.5) <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, S-UVM <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)	<input type="checkbox"/> Complete Blood Count <input type="checkbox"/> CBC auto diff/rflx manual diff <input type="checkbox"/> Hemoglobin & Hematocrit <input type="checkbox"/> Sed Rate <input type="checkbox"/> PT/INR <input type="checkbox"/> PTT <input type="checkbox"/> D-Dimer <hr/> <p align="center">PRESCRIPTION DRUGS</p> <input type="checkbox"/> Clozapine <input type="checkbox"/> Digoxin <input type="checkbox"/> Lithium <input type="checkbox"/> Phenytoin (Dilantin) <input type="checkbox"/> Valproic Acid (Depakene) <hr/> <p align="center">BLOOD BANK</p> <input type="checkbox"/> ABO/Rh Type <input type="checkbox"/> Antibody Screen <input type="checkbox"/> Direct Antiglobulin Test <hr/> <p align="center">SEROLOGY-IMMUNOLOGY</p> <input type="checkbox"/> ANA (antinuclear AB Screen- Mayo) <input type="checkbox"/> Celiac Disease Serology Cascade- Mayo <input type="checkbox"/> Fibro Test-ActiTest- Mayo <input type="checkbox"/> HCV Genotype – Mayo <input type="checkbox"/> Hepatitis A Total Antibody (IgG/IgM) <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 Antibody, S-UVM <input type="checkbox"/> Measles IgG Ab, S-UVM <input type="checkbox"/> Mononucleosis screen <input type="checkbox"/> Mumps Ab IgG, S-UVM <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"/> Anaplasma/Babesia by PCR, UVM <input type="checkbox"/> Babesia microti Ab S-Mayo <input type="checkbox"/> Varicella IgG Ab, S-UVM <hr/> <p align="center">URINE TESTS</p> <input type="checkbox"/> Microalbumin Level Urine <input type="checkbox"/> Urinalysis (UA w/ microscopic if indicated) <input type="checkbox"/> Urinalysis w/ micro + culture (if indicated) <input type="checkbox"/> Urine Culture <input type="checkbox"/> Urine Cytology (Path Non-Gyn) <input type="checkbox"/> Voided <input type="checkbox"/> Cath spec <input type="checkbox"/> Urine Drug Screen <input type="checkbox"/> Basic (5) <input type="checkbox"/> Expanded (11)	Please indicate source/site: <input type="checkbox"/> Blood Culture <input type="checkbox"/> Fungus Culture - skin / hair / nails <input type="checkbox"/> Sputum Culture <input type="checkbox"/> Group B Strep PCR <input type="checkbox"/> Group A Strep PCR <input type="checkbox"/> Wound Culture <input type="checkbox"/> Varicella Zoster Virus PCR (VZV)-UVM <input type="checkbox"/> Herpes Simplex Virus 1 & 2 (HSV)-UVM <input type="checkbox"/> COVID, Flu A/B, RSV, Rhinovirus PCR <hr/> <p align="center">STI/UROGENITAL MOLECULAR</p> <input type="checkbox"/> Mycoplasma genitalium <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Neisseria Gonorrhoeae (NG) <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Chlamydia trachomatis (CT) <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Trichomonas Vaginalis- Mayo <input type="checkbox"/> Swab <input type="checkbox"/> Urine <input type="checkbox"/> Vaginitis Panel (Hologic Aptima Multitest Swab) <hr/> <p align="center">STOOL TESTS</p> <input type="checkbox"/> GI Pathogen PCR (requires two diagnosis codes) <input type="checkbox"/> Lactoferrin (stool WBC) <input type="checkbox"/> Ova and Parasite- Mayo <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 <hr/> <p align="center">PATHOLOGY</p> <input type="checkbox"/> Pathology Tissue Biopsy <hr/> <p align="center">OTHER TESTS</p> <hr/> <p align="center">RRMC PATIENT LABEL</p>

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** - Hep C Virus (HCV) RNA Quant w/ Reflex to HCV Genotype, S- Mayo
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), Enteropathogenic 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 Panel** – COVID, Influenza A/B, Rhinovirus and RSV
11. **Urine Drug Screen Basic**- Amphetamine, Cannabinoid, Cocaine, Opiates, Phencyclidine
12. **Urine Drug Screen Expanded**- Amphetamine, Barbituates, Benzodiazepines, Bupernorphine, Cannabnoid, Cocaine, Fentanyl, Methadone, Opiates, Oxycodone, Phencyclidine

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

