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First Systems & Resources, Inc. (434) 973-4152 Fax (434) 973-6892

University of Virginia Health System

CLINICAL PATHOLOGY LABORATORY REQUEST

CHECK APPROPRIATE BOX FOR BILLING

☐ INSURANCE BILLING: COMPLETE SECTION 1-5 BELOW

☐ PATIENT BILLING (SELF PAY): COMPLETE SECTION 1-2 BELOW

☐ GRANT ACCOUNT ____________

☐ WHOLESALE/ACCOUNT ____________

3000001

PATIENT NAME (LAST, FIRST, MI) - PLEASE PRINT LAST FIRST MIDDLE

SEX ☐ M ☐ F

PATIENT HISTORY #

DOB

PHYSICIAN NAME (LAST, FIRST)

PHONE/PIC #

PHYSICIAN SIGNATURE

PATIENT LOCATION

DATE & TIME OF COLLECTION

ICD-9 Code(s) are required with every lab order

1. PATIENT ADDRESS (STREET OR PO BOX)

CITY/STATE

ZIP CODE

2. PATIENT PHONE #

PATIENT SOCIAL SECURITY #

PATIENT MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

RACE ☐ W ☐ B ☐ OTHER

GUARANTOR NAME (LEAVE BLANK IF PATIENT IS GUARANTOR)

GUARANTOR PHONE #

RELATIONSHIP TO PATIENT

GUARANTOR ADDRESS (STREET OR PO BOX)

CITY/STATE

ZIP CODE

3. MEDICARE: PRIMARY/SECONDARY

MEDICARE # & LETTER

4. MEDICAID #

STATE

EFFECTIVE DATE

5. OTHER INSURER ☐ PRIMARY ☐ SECONDARY

COMPANY NAME

ADDRESS

PHONE #

EFFECTIVE DATE

SUBSCRIBER NAME

POLICY #

GROUP #

ICD9 CODE	TEST NAME	TEST CODE
	GENERAL LAB TESTING	
______	☐ Albumin	(ALB)
______	☐ Alpha Fetoprotein (Tumor)	(AFPT)
______	☐ ALT (GPT)	(ALT)
______	☐ Amylase	(AMY)
______	☐ ANA*	(ANAHU)
______	☐ Anti DS DNA (Crithidia)	(ANTIDN)
______	☐ Anti-Extract Nuclear Antigens	(ANTIEN)
______	☐ AST (GOT)	(AST)
______	☐ Bilirubin, Total	(TBIL)
______	☐ BNP	(BNP)
______	☐ BUN	(BUN)
______	☐ Calcium	(CA)
______	☐ Carbamazepine	(CARBMZ)
______	☐ Cardiolipin IgG and IgM Antibodies	(ANTICA)
______	☐ CBC Profile ☐ STAT [includes Platelets & Diff(1)]	(CBCPR)
______	☐ CBC w/ Platelets ☐ STAT	(CBC)
______	Celiac Screen, order separately ☐ IGA ☐ TTGA	
______	☐ CEA	(CEA)
______	☐ Basic, Chem Panel ☐ STAT (Na, K, Cl, CO_2, BUN, Crea, Gluc, Ca)	(CPBAS)
______	☐ Compreh., Chem Panel ☐ STAT (CPBAS, TP, Alb, TBil, Alkp, Alt, Ast)	(CPCOM)
______	☐ Electrolytes, Chem Panel ☐ STAT (Na, K, Cl, CO_2)	(CPELEC)
______	☐ Hepatic, Chem Panel ☐ STAT (TP, Alb, CBil, TBil, Alkp, Alt, Ast)	(CPHEP)
______	☐ Cholesterol	(CHOLB)
______	☐ Chlamydia Screen...Site: ______	(CLAPCR)
______	☐ GC Screen...Site: ______	(GCPCR)
______	☐ CMV IgG Screen	(CMVSCR)
______	☐ CMV Viral Load	(CMVVL)
______	☐ CK	(CPK)
______	☐ Conjugated Bilirubin	(CBIL)
______	☐ Cortisol	(CORT)
______	☐ Creatinine	(CREA)
______	☐ C Reactive Protein	(CRP)
______	☐ Cyclosporin	(CYCLOS)
______	☐ DHEA-Sulfate	(DHESO4)
______	☐ Digoxin	(DIGOX)
______	☐ EBV Immune Status	(EBVIM)
______	☐ Estradiol	(ESTRA)
______	☐ Ferritin	(FERITN)
______	☐ FK506 / Tacrolimus	(FK506)
______	**Flow Cytometry*** (CBCPR required)	
______	☐ T, B, Natural Killer Cell Flow Panel	(TBNK)
______	☐ T Helper Suppressor Panel	(THS)
______	☐ Folate	(FOLATE)
______	☐ Follicle Stimulating Hormone	(FSH)
______	☐ Gamma Glutamyltransferase	(GGT)

ICD9 CODE	TEST NAME	TEST CODE
______	☐ Glucose ☐ STAT	(GLUC)
______	☐ Growth Hormone	(GH)
______	☐ HCG, Qualitative	(HCGQL)
______	☐ HCG, Quantitative	(HCGQN)
______	☐ Heliobacter Pylori	(HPELIS)
______	☐ Hemoglobin A1C	(HGBA1C)
______	☐ Hep C Viral Load (Quant.)	(HEPCVL)
______	☐ Hep C Viral Load (High Level)	(HEPCVC)
______	☐ Hepatitis B Surface Antigen*	(HBSAG)
______	☐ Hepatitis B Core Antibody	(HBCAB)
______	☐ Hepatitis B Surface Antibody	(HBSAB)
______	☐ Hepatitis C Antibody	(HCVAB)
______	☐ Hepatitis A Antibody, IgM	(HAVM)
______	☐ Hgb Electrophoresis*	(HGBEP)
______	☐ HIV Antibody* (patient consent required)	(HIV12)
______	☐ HIV Viral Load (Quant.)	(HIVVLD)
______	☐ Homocysteine, Plasma	(HCYST)
______	☐ IgE	(IGE)
______	☐ Ig Quantitation (IgG, IgA, IgM)	(QUANT)
______	☐ Low HIV Viral Load (ultrasensative)	(LHIVL)
______	☐ Insulin-Like Growth Factor	(IGF1)
______	☐ Iron & Transferrin	(FETRAN)
______	☐ LDH	(LDH)
______	☐ Lipase	(LIPA)
______	☐ Lipid Panel (CHOL, HDL, LDL, TRIG)	(LIPID)
______	☐ Luteinizing Hormone	(LUH)
______	☐ Magnesium	(MG)
______	☐ Ovarian Cancer Antigen	(OCA125)
______	☐ Parathyroid Hormone	(PTHINT)
______	☐ Partial Thromboplastin ☐ STAT	(PTT)
______	☐ Phenytoin	(PTN)
______	☐ Phosphorous	(PHOS)
______	☐ Potassium	(K)
______	Prenatal Panel, order separately ☐ CBC ☐ RPR* ☐ HBsAg* ☐ Rubella IgG ☐ HIV12*	
______	☐ Progesterone	(PROG)
______	☐ Prolactin	(PRL)
______	☐ Protein Electrophoresis*	(SPEP)
______	☐ Prothrombin Time-INR ☐ STAT	(PT)
______	☐ Prostate Specific Antigen (DIAG)	(PSA)
______	☐ Prostate Specific Antigen (SCRN)	(PSASC)
______	☐ Reticulocytes	(RETICS)
______	☐ Rheumatoid Factor	(RF)
______	☐ RPR*	(RPR)
______	☐ Rubella IgG	(RUBLTX)
______	☐ Sedimentation Rate	(ESR)
______	☐ Testosterone	(TESTOS)
______	☐ Bio Available Testosterone	(BIOT)
______	☐ Thy Microsomal Antibody	(AMICR)

ICD9 CODE	TEST NAME	TEST CODE
______	☐ T3, Total	(TOT3)
______	☐ Free Thyroxine (Free T4)	(FREET4)
______	☐ Thyroid Hormone Uptake	(T3U)
______	☐ Thyroid Stimulating Hormone	(TSH)
______	☐ T3, Free	(FRET3)
______	☐ Thyroxine, Total	(T4)
______	☐ TSH w/reflex Free T4 (Orders Free T4 if > 6.4 or < 0.4)	(TSHR)
______	☐ Triglyceride	(TRIGB)
______	☐ Troponin I	(TROPI)
______	☐ Uric Acid	(URIC)
______	☐ Valproate	(VALP)
______	☐ VAP Test	(QVAP)
______	☐ Vitamin B12	(B12)
	BLOOD BANK SECTION	
	Med. Surg. Date ______	
______	☐ Type and Screen*	(TAS)
______	☐ Type and Hold (Typenex)	(TYHD)
______	☐ Red Blood Cells	qty.____
______	☐ Fresh Frozen Plasma	qty.____
______	☐ Platelets	qty.____
______	☐ CMV Reduced Risk	
______	☐ Irradiated	
______	☐ Leukocyte-Reduced	
______	☐ Antibody Titer	(TITER)
______	☐ Direct Coombs Test	(DCT)
______	☐ ABO Type	(ABONLY)
______	☐ ABO Type and RH	(ABRH)
______	☐ RH Only	(RHONLY)
	URINE TESTING **SPOT** **TIMED**	
______	☐ Albumin/Creatinine Ratio ☐ ____HR	(UACR)
______	☐ Calcium (UCALCM) ☐ ____HR	(UTFCA)
______	Creatinine Clearance ☐ ____HR	(CRCL)
______	☐ Creatinine (UCREA) ☐ ____HR	(UTFCRE)
______	☐ Microalbumin (MALB) ☐ ____HR	(MALB)
______	☐ Protein Electrophoresis* (UPEPSP) ☐ ____HR	(UPEPTP)
______	☐ Urine Free Cortisol ☐ ____HR	(JCORTU)
______	☐ Urine Total Protein (UTP) ☐ ____HR	(UTFTP)
______	Catecholamines ☐ ____HR	(UCAT)
______	Metanephrines & Normetanephrines ☐ ____HR	(UMNT)
______	Vanilmandelic Acid ☐ ____HR	(URVMA)
______	☐ Urinalysis ☐ STAT	(UASCR)
______	☐ Urinalysis with reflex to culture if indicated	(UACUL)
	Total volume ______	
	CULTURE	
	Source/Site: (Required) ______	
______	☐ Culture Group B Strep	(CBS)
______	☐ Group A Beta Strep, Culture (Culture confirmation for negative rapid screen in office)	(CTS)
______	☐ Rapid Group A Beta Strep Culture (Rapid screen + culture confirmation if negative)	(TS)
______	☐ Urine Culture	(UC)

Other:

PROOF

Every effort has been made to provide this proof error-free. However, since mistakes do occur, we ask that you carefully check its contents for spelling, punctuation & arrangement. Final approval becomes your responsibility when signing off... *Thank you*

☐ Approved WITHOUT changes

☐ Approved WITH changes as marked on the proof.

Signed ______

Additional Patient Information:

Phone Results To

Fax Results To

NOTE: *Denotes tests that will have automatic reflex confirmation performed upon positive screen result unless otherwise indicated.
(1) Abnormal cellular findings may result in a professional fee for pathologist review.

LAB COPY

UVA050 33215 (3-06)