

# Laboratory Request Form

## General Procedures

<b>ORDERED BY:</b> Name: _____ Facility: _____  Specimen Collected by: _____	<b>PRIORITY</b> Collection, processing and reporting will be routine unless checked below. ME <input type="checkbox"/> Life-Threatening EX <input type="checkbox"/> ASAP PW <input type="checkbox"/> Patient Waiting AM <input type="checkbox"/> Morning Draw TS <input type="checkbox"/> Draw at _____	<b>PATIENT INFORMATION</b>   <b>PATIENT TYPE/CHART LOCATION</b> LOC _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pre-op Fac: _____ Date of surgery: _____ <input type="checkbox"/> Pre-admit Fac: _____ Date of admit: _____ <input type="checkbox"/> Prenatal <input type="checkbox"/> Premarital <input type="checkbox"/> Health Appraisal <input type="checkbox"/> <b>COPY REPORT TO:</b> _____ <input type="checkbox"/> _____ _____
<b>COMMENTS</b> <input type="checkbox"/> R/O _____ <input type="checkbox"/> PE _____ <input type="checkbox"/> Hx of _____ <input type="checkbox"/> Pre-emp _____ <b>P PRINT WITH RESULTS:</b> <input type="checkbox"/> Follow Up _____ <input type="checkbox"/> Day of Cycle _____ <input type="checkbox"/> Call Patient <input type="checkbox"/> Prev. result _____ <input type="checkbox"/> LMP _____ <input type="checkbox"/> Non-fasting <input type="checkbox"/> Rx _____ <input type="checkbox"/> Do _____ before appt. <input type="checkbox"/> Fasting _____ hrs. <input type="checkbox"/> Sample # _____ <b>INSTRUCTIONS TO LAB /PATIENT:</b>		

CHEMISTRY			
<input type="checkbox"/> Sodium <b>NA</b>	<input type="checkbox"/> Chloride <b>CL</b>	<input type="checkbox"/> Ferritin <b>FERR</b>	<input type="checkbox"/> SGPT (ALT) <b>ALT</b>
<input type="checkbox"/> Potassium <b>K</b>	<input type="checkbox"/> Carbon Dioxide <b>CO2</b>	<input type="checkbox"/> Iron/TIBC <b>IRON/TIBC</b>	<input type="checkbox"/> CPK (CK) <b>CK</b>
<input type="checkbox"/> Creatinine <b>CREAT</b>	<input type="checkbox"/> Calcium <b>CA</b>	<input type="checkbox"/> Hgb Electrophoresis <b>HGB EP</b>	<input type="checkbox"/> CKMB <b>CKMB</b>
<input type="checkbox"/> BUN <b>BUN</b>	<input type="checkbox"/> Phosphorous <b>PHOS</b>	<input type="checkbox"/> T4/FTI <b>T4S</b>	<input type="checkbox"/> Amylase <b>AMYL</b>
<input type="checkbox"/> Glucose – fasting <b>GLUCF</b>	<input type="checkbox"/> Uric Acid <b>URIC</b>	<input type="checkbox"/> TSH <b>TSH</b>	<input type="checkbox"/> Cholesterol <b>CHOL</b>
<input type="checkbox"/> Glucose – random <b>GLUCR</b>	<input type="checkbox"/> Total Bilirubin <b>BILIT</b>	<input type="checkbox"/> Alk Phos <b>ALKP</b>	<input type="checkbox"/> HDL <b>HDL</b>
<input type="checkbox"/> Hemoglobin A1C <b>HGBA1C</b>	<input type="checkbox"/> Neonate T. Bilirubin <b>BILITN</b>	<input type="checkbox"/> SGOT (AST) <b>AST</b>	<input type="checkbox"/> LDL – fasting <b>LDL</b>
<input type="checkbox"/> Fructosamine <b>FRU/ALB</b>	<input type="checkbox"/> Serum Protein Elect. <b>PEP</b>	<input type="checkbox"/> Albumin <b>ALB</b>	<input type="checkbox"/> Triglycerides – fasting <b>TRIG</b>
<input type="checkbox"/> PSA <b>PSA</b>			

SEROLOGY			
<input type="checkbox"/> RPR (VDRL) <b>RPR</b> <input type="checkbox"/> Mono <b>MONO</b> <input type="checkbox"/> Serum Pregnancy <b>PREGS</b> <input type="checkbox"/> Quant. Beta HCG <b>BHCG</b> <input type="checkbox"/> ANA <b>ANA</b> <input type="checkbox"/> Rheumatoid Factor <b>RA</b> <input type="checkbox"/> Blood Group, Rh <b>ABORH</b> <input type="checkbox"/> Antibody Screen <b>ABSC</b> <input type="checkbox"/> Direct Coombs <b>DAT</b> <input type="checkbox"/> VDRL Cord Blood <b>CB VDRL</b>	<b>Hepatitis A</b> <input type="checkbox"/> Hep A IgM (Acute) <b>HAM</b> <input type="checkbox"/> Hep A IgG (Immunity) <b>HAG</b> <hr/> <b>Hepatitis B</b> <input type="checkbox"/> Surface Ag <b>HBSAG</b> (Acute or chronic) <input type="checkbox"/> Core Ab <b>HBCAB</b> (Pre-vaccine) <input type="checkbox"/> Surface Ab (Immunity) <b>HBSAB</b> <hr/> <input type="checkbox"/> Hepatitis C Antibody <b>HCAB</b>	*** For the tests below check specimen <b>SPECIMEN TYPE</b> Serum: Paired Sample Single Sample Non-serum: <input type="checkbox"/> CSF <input type="checkbox"/> Rubella <b>RUB</b> <input type="checkbox"/> Rubeola <b>RUBEO</b> <input type="checkbox"/> Varicella <b>VARZ</b> <input type="checkbox"/> CMV <b>CMV</b> <input type="checkbox"/> H. pylori <b>HPY</b>	type box in addition to test order box:  <input type="checkbox"/> Acute <input type="checkbox"/> Conv <input type="checkbox"/> Immunity <input type="checkbox"/> Other _____ <input type="checkbox"/> Mumps <b>MUMPS</b> <input type="checkbox"/> Toxoplasma <b>TOXO</b> <input type="checkbox"/> Lyme <b>LYME</b> <input type="checkbox"/> _____

HEMATOLOGY	COAGULATION	TOXICOLOGY/DRUGS	BLOOD GASES
<input type="checkbox"/> Hemoglobin Hematocrit <b>HH</b> <input type="checkbox"/> CBC (w/o Differential) <b>CBC</b> <input type="checkbox"/> CBC with Differential <b>CBCD</b> <input type="checkbox"/> Reticulocyte Count <b>RETIC</b> <input type="checkbox"/> Westergren Sed Rate <b>ESR</b> <input type="checkbox"/> Hematocrit, Manual <b>HCTM</b> <input type="checkbox"/> T Lymphocyte Panel <b>TNB</b> <b>URINALYSIS</b> <input type="checkbox"/> Clean Catch <b>UA</b> <input type="checkbox"/> Catheter <input type="checkbox"/> Menstruating <input type="checkbox"/> Microscopic required <input type="checkbox"/> Culture per protocol <input type="checkbox"/> Urine Pregnancy <b>PREGU</b> <input type="checkbox"/> Urine Microalbumin <b>U MICROALB</b>	Indicate Anticoagulant Therapy <input type="checkbox"/> None <input type="checkbox"/> Coumadin <input type="checkbox"/> Heparin (Circle Type) Continuous   Intermittent   LMW <input type="checkbox"/> _____ <b>Last Dose:</b> Date: _____ Time: _____  <input type="checkbox"/> Prothrombin Time INR <b>PT</b> <input type="checkbox"/> Activated PTT <b>APTT</b> <input type="checkbox"/> Fibrinogen <b>FIBR</b> <input type="checkbox"/> Fibrin Split Products <b>FSP</b> <input type="checkbox"/> D-Dimer <b>DDIMER</b> <input type="checkbox"/> _____	<input type="checkbox"/> Peak <input type="checkbox"/> Trough <input type="checkbox"/> Random  <b>Last Dose:</b> Date: _____  Time: _____  Route: _____  <input type="checkbox"/> Vancomycin <b>VANCO</b> <input type="checkbox"/> Gentamicin <b>GENT</b> <input type="checkbox"/> Theophylline <b>THEO</b> <input type="checkbox"/> Phenytoin <b>PHTN</b> <input type="checkbox"/> Carbamazepine <b>CARB</b> <input type="checkbox"/> Phenobarbital <b>PHENO</b> <input type="checkbox"/> Digoxin <b>DIG</b> <input type="checkbox"/> Lithium <b>LI</b> <input type="checkbox"/> _____	Includes pH, pCO <sub>2</sub> , pO <sub>2</sub> , HCO <sub>3</sub> , BE, O <sub>2</sub> Sat Temp oF _____ FIO <sub>2</sub> % _____ <input type="checkbox"/> Room Air  <input type="checkbox"/> Arterial <b>ABG</b> <input type="checkbox"/> Mixed Venous <b>VBG</b> <input type="checkbox"/> Capillary <b>CBG</b>  <b>OTHER</b> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
			DATE & TIME RECEIVED _____