PLACE ON TUBE

Clinical Blood Labwork Implementation



CLINICAL BLOOD LABWORK

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•	GS 076991	mm DD YYYY Jane Doe	GS 076991	mm / DD / YYYY Jane Doe
t e n healthcare (1)	1	National Name		National Phones
1636 Headland Dr. Fenton, MO 63026	GS 076991	mm, DD, YYYY	GS 076991	mm / DD / YYYY
Phone: (314) 200-3040 Fax (314) 200-3042 CAP: 8855089 CLIA: 26D0953866	ğ.	Jane Doe	,	Jane Doe
Blood Laboratory Test Requisition Form				

Blood Laboratory Test Requisition Form							
CLINIC INFORMATION HERE		DOE LAST NAME 1 Patient St.	FIRST NAME	/DD/YY .o.s. 200-3040			
н	EKE	STREET ADDRESS	ONE NUMBER				
		WHITE NO	N-HISPANIC "	_F X			
RACE ETHNICITY SEX Requesting Provider Collection Date Collection Time Centrifugation*							
		(4)MM/DD/YY	A.M	1			
F.W.							
(7) ICD-10 Diagnosis Codes Include codes that are medically appropriate for patient's condition and consistent with medical record. Billing Information							
D51.9 Vitamin B12 deficiency anemia, unsp D64.9 Anemia, unspecified	pecified	Z00.00 Encounter for general adult medical examination without abnormal findi		_			
E28.8 Other ovarian dysfunction		Z00.01 Encounter for general adult medical examination with abnormal findings					
E35 Disorders of endocrine glands in dise	pases classified elsewhere	Z01.812 Encounter for preprocedural laborat Z01.89 Encounter for other specified specia	☐ SELF PAY				
F52.8 Other sexual dysfunction not due to physiological condition		Z13.6 Encounter for screening for cardiova Z20.5 Contact with and (suspected) exposu	ascular disorders	_ SEE TAI			
I10 Essential primary hypertension		Z51.81 Encounter for therapeutic drug level		CLIENT BILL			
N52.9 Male erectile dysfunction, unspecifie	ed	Other:					
N91.2 Amenorrhea, unspecified N95.9 Unspecified menopausal and perime							
		or preferred tube typ					
	Collect specimen in	appropriate tube as specified for	r desired testing				
SERUM W/SEPARATOR [SST] YELLOW TOP [K2 EDTA] PURPLE TOP GRAY T							
	TEN.	Clinian Diagram	.1.				
		Clinical Blood Labwoi					
Anemia Panel [SST]	Comprehensive Metabolic Panel [SST]	Men's Health Panel [SST]	Thyroid Panel [SST]	Infectious Diseases [SST]			
Inlcudes all assays listed below:	Inlcudes all assays listed below:	Inlcudes all assays listed below:	Inlcudes all assays listed below:	Anti-HAV			
Ferritin Folate	☐ Alanine Aminotransferase (ALT) ☐ Albumin	Cortisol DHEA-S	Free T3 (FT3) Free T4 (FT4)	☐ Anti-HAV IGM ☐ Anti-HBc			
☐ Iron	Alkaline Phosphatase	Follicle-Stimulating Hormone (FSH)	☐ Thyroid-Stimulating Hormone (TSH)	Anti-HBc IGM			
Transferrin	Aspartate Aminotransferase (AST)	Luteinizing Hormone (LH)	Thyroxine (T4)	Anti-HBs			
☐ Unsaturated Iron Binding Capacity (UIBC) ☐ Vitamin B12	☐ Bicarbonate (CO2) ☐ Bilirubin - Total	Prolactin Testosterone	☐ Thyroxine-Binding Capacity (T-Uptake) ☐ Tri-iodothyronine (T3)	☐ Anti-HCV ☐ HBeAG			
☐ Vitamin D	Calcium	☐ Women's Health Panel [SST]	General Chemistry [SST]	HBsAg w/ applicable confirmatory			
Basic Metabolic Panel [SST]	Chloride (Cl-)	Inlcudes all assays listed below:	Alanine Aminotransferase (ALT)	Herpes Simplex 1 (HSV-1 IgG)			
Inlcudes all assays listed below: Bicarbonate (CO2)	☐ Creatinine ☐ Glucose [SST or NaF]***	Cortisol DHEA-S	☐ Albumin ☐ Alkaline Phosphatase	Herpes Simplex 2 (HSV-2 IgG) HIV Duo			
Calcium	Dotassium (K+)	Estradiol	☐ Amylase - Total	Syphilis			
Chloride (CI-) Creatinine	Sodium (Na+) Total protein	Follicle-Stimulating Hormone (FSH)	Aspartate Aminotransferase (AST) Bicarbonate (CO2)	Specific Protein [SST]			
Glucose [SST or NaF]***	Urea/BUN	HCG+Beta Luteinizing Hormone (LH)	Bilirubin - Direct	☐ Alpha-1 Antitrypsin ☐ Anti-Streptolysin O			
Potassium (K+)	☐ Diabetes Panel	☐ Progesterone	☐ Bilirubin - Total	Beta2 Microglobulin			
Sodium (Na+)	Inlcudes all assays listed below:	Prolactin	Calcium	Ceruloplasmin			
☐ Urea/BUN ☐ Cardiac Panel [SST]	Fructosamine [SST] Glucose [SST or NaF]***	☐ Testosterone ☐ Renal Panel [SST]	Chloride (CI-) Creatinine	Complement 3 (C3) Complement (C4)			
Inlcudes all assays listed below:	Hemoglobin A1c [K2 EDTA]	Inlcudes all assays listed below:	☐ Creatinine Kinase (CK)	C-Reactive Protein (CRP)			
Apolipoprotein A Apolipoprotein B	☐ Insulin [SST] ☐ Growth [SST]	Albumin Bicarbonate (CO2)	Gamma GlutamylTransferase (GGT) Kappa Free Light Chain	Cystatin C Haptoglobin			
Cholesterol - Total	IGF-1	Calcium	Lactate Dehydrogenase (LDH)	Homocysteine			
C-Reactive Protein, High-Sensitivity	Hepatic Panel [SST]	Chloride (Cl-)	Lambda Free Light Chain	☐ IgA			
Digoxin** High-Density LipoProtein (HDL)	Inlcudes all assays listed below: Alanine Aminotransferase (ALT)	Creatinine Glucose [SST or NaF]***	Lipase Magnesium	☐ IgG			
Lipoprotein A	Albumin Albumin	Phosphate	Phosphate	PreAlbumin			
Low-Density Lipoprotein	Alkaline Phosphatase	Potassium (K+)	Potassium (K+)	Rheumatoid Factor			
ProBNP Triglycerides	Aspartate Aminotransferase (AST) Bilirubin - Direct	☐ Sodium (Na+) ☐ Urea/BUN	Sodium (Na+) Total protein				
Complete Blood Count [K2 EDTA]	☐ Bilirubin - Total		☐ Urea/BUN				
Automated Complete Blood Count PATIENT AUTHORIZATION:	☐ Total protein		☐ Uric Acid				
provider with my insurer. If my current policy prol	f this testing to the treating physician or facility. I hereby hibits direct payment to TEN Healthcare, I agree to receive	e the funds and relinquish them to TEN Healthcare as p					
	mation needed to determine these benefits payable for re	elated services.					
Patient Signature: Jame One (11)							
$(2\lambda)^{-1}$ (12)							
Physician Signature: Dr. Sest (12) Date: MM/DD/YY							
*Centrifugation criteria: The following assays need	to be centrifuged according to the time frames listed below	ow if using the serum separator tube (SST)					
-Glucose-30 minutes from collection -Iron (Fe)-1 hour from collection							
-Anti-HBC & Anti-HBC IGM-2 hours from collection							
Samples for Digoxin testing should be drawn immediately before the next dose or after 12 hours from previous dose. *Sodium Flouride tube to be used for Glucose if not centrifuged.							

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INSTRUCTION NOTES:

- (1) Fill out Stickers and Place On Sample Tubes
- (2) Patient DEMO Information (Name, DOB, Address, Phone, Race, Ethnicity, Sex)
- (3) Requesting Provider (e.g., "Dr. Test")
- (4) Date of Collection
- (5) Time of Collection
- (6) Indicate if Sample has been Centrifuged
- (7) Select Applicable Diagnosis Codes
- (8) Select Billing Method (Insurance, self pay, or client bill)
- (9) Key to Determine Appropriate Sample Tube
- (10) Select Desired Testing for Sample (Individual Assays or Comprehensive Panels)
- (11) Patient Signature and Date
- (12) Physician Signature and Date

PLEASE ATTACH

- (A) Patient's Facesheet / Demographics
- (B) Patient Insurance Card (if available)