

**CLINICAL TEST REQUEST FORM**

SHADED AREAS FOR PATIENT INFORMATION REQUIRED				STAT	COLLECTION DATE	TIME	REPORT								
				<input type="checkbox"/>	/ /	AM/PM	<input type="checkbox"/> CALL <input type="checkbox"/> FAX								
PATIENT LAST NAME				FIRST NAME				MI							
DOB				GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				PT. ID# / ADDITIONAL INFO							
SSN				BILL <input type="checkbox"/> OFFICE/CLIENT <input type="checkbox"/> PATIENT INSURANCE				PROVIDER: _____ (Last, First, MI)							
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED				Account Number				Account Name							
GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)				PHONE NUMBER				Street Address							
ADDRESS				CITY		STATE	ZIP								
PRIMARY INSURANCE <input type="checkbox"/> MEDICARE IN-PATIENT <input type="checkbox"/> MEDICARE OUT-PATIENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE				POLICY ID#				City							
INSURANCE COMPANY				PHONE NUMBER				State							
INSURANCE COMPANY ADDRESS				CITY		STATE	ZIP								
EFFECTIVE DATE				DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)				City							
ICD-10 #1				ICD-10 #2		ICD-10 #3		State							
NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. TESTING IN GRAY MAY REQUIRE AN ABN. FOR MORE INFORMATION SEE <a href="http://reglab.org/billingcompliance/">reglab.org/billingcompliance/</a>				SECONDARY / TERTIARY INS – ATTACH INFORMATION				Zip Code							
				<input type="checkbox"/> ABN ATTACHED				Phone Number							
				<input type="checkbox"/> PRIOR AUTHORIZATION ATTACHED				Fax Number							
<b>EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER</b>				<b>EACH TEST ORDERED MUST BE CODED WITH A DIAGNOSIS NUMBER</b>											
1 2 3	PANELS (see components on back of form)			1 2 3	INDIVIDUAL TESTS			1 2 3	INDIVIDUAL TESTS			1 2 3	**MICROBIOLOGY/VIROLOGY		
	BASIC METABOLIC	LG		CEA		S		PHOSPHORUS		LG		AFB CULTURE*: _____			source: _____
	ELECTROLYTES	LG		CHOLESTEROL		LG		POTASSIUM		LG		AEROBIC CULTURE: _____			source: _____
	COMPREHENSIVE METABOLIC	LG		CHRONIC HEART FAILURE PEPTIDE (CHFP)		L		PROLACTIN		LG		ANAEROBIC CULTURE: _____			source: _____
	LIPID	LG		CK <input type="checkbox"/> CKMB		LG		PROTEIN ELECTROPHORESIS, SERUM		S		BLOOD CULTURE: <input type="checkbox"/> ADULT (BLDCU)			<input type="checkbox"/> PEDIATRIC (BLDA)
	HEPATIC LIVER FUNCTION	S		CREATININE		LG		PROTEIN, TOTAL		LG		source: _____			
	OBSTETRIC (OB PNL)	S, L		CORTISOL ____ 8 AM ____ 4 PM		LG		PROTIME _____ Anticoagulant		LB		BORDETELLE PERTUSSIS CULTURE: _____			source: _____
	HEPATITIS PANEL, ACUTE	S		ESTRADIOL		LG		PTT _____ Anticoagulant		LB		C. DIFFICILE TOXIN* (Stool)			
	CELIAC DISEASE SCREEN	S		FERRITIN		LG		PSA <input type="checkbox"/> SCREEN <input type="checkbox"/> DIAGNOSTIC		S		FUNGAL CULTURE: _____			source: _____
	ALLERGY PANEL IgE PEDS MARCH	S		FOLIC ACID (Folate, Serum)		LG		PROGESTERONE		S		FUNGAL-DERMATOPHYTE CULTURE: _____			source: _____
	ALLERGY PANEL IgE REGION 9	S		FSH		LG		RETICULOCYTE COUNT		L		GC/CHLAMYDIA PROBE: _____			source: _____
	ALLERGY PANEL IgE FOOD ALLERGENS	S		LH		LG		RHEUMATOID FACTOR		S		source: _____			
1 2 3	<b>INDIVIDUAL TESTS</b>			HCG QUALITATIVE (Pregnancy Test)			S	RUBELLA, IgG		S		GASTROINTESTINAL PATHOGEN PANEL (GIP)			
	A-FETOPROTEIN TUMOR MKR	S		HCG QUANTITATIVE		S		SED RATE (ESR)		L		HELICOBACTER PYLORI ANTIGEN* (Stool)			
	ALT	LG		GAMMA GT		LG		SYPHILIS IgG SCREEN		S		OVA & PARASITE: <input type="checkbox"/> Foreign Travel (OVPAR)			<input type="checkbox"/> No Travel (OVPCY)
	AMYLASE	LG		GLUCOSE ____ Fasting ____ Non Fasting		LG		T4 (Free)		S		SPUTUM CULTURE*			
	ANA IFA w reflex to titer and ANAPN (ANAFIX)	S		HEMOGLOBIN A1C (Glycolated Hgb)		L		TB INTERFERON		SPECIAL		RAPID GROUP A STREP SCREEN (Throat)			
	ANA Screen with reflex to ANAPN (ANASCR)	S		HEMOGLOBIN & HEMATOCRIT		L		TESTOSTERONE (TST), TOTAL		S		RESPIRATORY PATHOGEN PNL BY PCR* (RESPP)			
	ANA IFA with titer (ANAIF)	S		HEPATITIS A Ab(IgM)		S		TST PANEL - Males (SHBG, tTST, fTST, %fTST): TSFTST		S		STREP GROUP A CULTURE (Throat)			
	ABO/RH/ANTIBODY SCREEN	L		HEPATITIS B CORE Ab (Total) IgG, IgM		S		TST PANEL - Female & Children: TESTOS		S		TISSUE CULTURE*: _____			source: _____
	AST	LG		HEPATITIS B SURFACE Ab (HBsAb)		S		TSH, Ultra Sensitive		LG		GROUP B STREP CULTURE*: _____			source: _____
	BILIRUBIN <input type="checkbox"/> TOT <input type="checkbox"/> DIR	LG		HEPATITIS B SURFACE Ag (HBsAg)		S		URIC ACID		LG		URINE CULTURE*: _____			source: _____
	BUN	LG		HEPATITIS C Ab		S		URINALYSIS (Dipstick, microscopic if indicated)		U		VAGINAL PATHOGENS PCR			(Trichomonas, Candida, Bacterial Vaginosis)
	C-REACTIVE PROTEIN (CRP) HIGH Sens	LG		HEPATITIS C Ab with reflex to Hep C RNA Quant		S		URINALYSIS (Dipstick + microscopic)		U		VITAMIN B12			1 2 3
	C-REACTIVE PROTEIN (CRP)	LG		HEPATITIS PANEL, ACUTE		S		VITAMIN D TOTAL SCREENING ASSAY (VITD)		S		Provide source for testing below			
	CALCIUM	LG		HEPATITIS PANEL, ACUTE with reflex to Hep C RNA Quant		S		WEST NILE IgG, M <input type="checkbox"/> SERUM <input type="checkbox"/> CSF		S		ADENOVIRUS DNA DETECTION			
	CA 125	S		HERPES SIMPLEX VIRUS 1 AND 2		S		<b>TIMED URINE TEST</b>				CMV DNA DETECTION			
	CA 15-3	S		HIGH-SENSITIVITY TROPONIN I		LG		TEST NAME				ENTEROVIRUS RNA DETECTION			
	CA 19-9	S		HIV Panel (HIV-1 p24, HIV-1 Ab, HIV-2 Ab)		S		____ Hrs. Collected    ____ Total Volume				HERPES VIRUS PANEL (CMV/HSV/EBV/VZV/HHV-6)			
	CBC (Autodiff, plt ct) (CBCP)	L		IRON <input type="checkbox"/> TIBC (inc: Transferrin)		LG	1 2 3	<b>DRUG LEVELS</b>				HSV 1 & 2 DNA DETECTION AND GENOTYPE			
	CBC w/o Diff (HEMOGRAM) (SCTP)	L		LD		LG		DRUG _____ R				HSV DNA DIRECT DETECTION			
				LIPASE		LG		____ PRE    ____ POST    ____ RANDOM				HUMAN HERPES VIRUS 6 (HHV6) DNA DETECTION			
				MAGNESIUM		LG	1 2 3					VARICELLA ZOSTER VIRUS DNA DETECTION			
				MICRO ALBUMIN, URINE ____ Random ____ 24hr		U									
				MONOSPOT		S									
ADDITIONAL TEST INFO/COMMENTS															

FOR DETAILED TESTING INFORMATION VISIT [REGLAB.ORG](http://REGLAB.ORG)

SPECIMEN CODES: \* = REFERRERATE S = SST (GOLD) U = URINE L = LAVENDER LB = LIGHT BLUE R = RED/CLOT LG = LIGHT GREEN RB = ROYAL BLUE  
\*\* BACTERIAL CULTURES INCLUDES: GRAM STAIN, ID AND SENSITIVITY IF INDICATED



## **Testing Supplies**

**Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.**

Supplies are ordered online at [reglab.org/customer-service/supply-orders/](http://reglab.org/customer-service/supply-orders/) testing supplies and log-on information may be obtained by calling Client Services  
Toll Free 800-334-0459  
Phone 402-559-6420

## **Courier Services**

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call  
client services Toll Free 800-334-0459  
Phone 402-559-6420

If shipping specimens address to:  
UNMC Shipping & Receiving Dock  
Regional Pathology Services MSB 3500  
University of Nebraska Medical Center  
601 Saddle Creek Road  
Omaha, NE 68106-1180

## **Transport Instructions:**

### **Specimen Handling/Shipping**

To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at [reglab.org](http://reglab.org) for more information.

### **Questions?**

Contact client services at 800-334-0459