LAB SERVICES FAX ORDER FORM

HUNTSVILLE HOSPITAL
LABORATORY SERVICES

PLEASE FAX TO 256-265-6231

☐ MED MALL ☐ MADISON 72
☐ EAST MOB ☐ STH MADISON
☐ BLACKWELL ☐ HAMPTON COVE
☐ STH HSV ☐ HAZEL GREEN

Expected Date of Service _____

Ordering physician: _____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Order initiated by: _____
(Please sign or initial)

Diagnosis: _____

FOR LAB USE:
CLIENT CODE: _____

PHLEBOTOMY CODE: _____
DATE & TIME COLLECTED:
___/___/___ ____:____

PROFILES

☐ ACUTE HEPATITIS PANEL
☐ ARTHRITIS PANEL
☐ BASIC METABOLIC PANEL
☐ COMPREHENSIVE METABOLIC
☐ ELECTROLYTE PANEL
☐ HEPATIC FUNCTION PANEL
☐ LIPID PANEL
☐ OBSTETRIC (PRENATAL)
☐ RENAL FUNCTION PANEL
☐ TORCH ANTIBODY PANEL

INDIVIDUAL TESTS

☐ ALBUMIN
☐ ALK PHOS
☐ ALT (SGPT)
☐ ANA
☐ AST (SGOT)
☐ BILI, TOTAL ☐ BILI, DIRECT
☐ BUN
☐ CALCIUM
☐ CBC w/DIFF
☐ CBC, no DIFF
☐ CEA
☐ CHLORIDE
☐ CHOLESTEROL
☐ CO2
☐ CPK
☐ CREAT CLEARANCE, 24 HR URINE
HEIGHT_____ WEIGHT_____

☐ CREATININE SERUM
☐ DIGOXIN (PHENYTOIN)
☐ DILANTIN (PHENYTOIN)
☐ FERRITIN
☐ FSH ☐ LH ☐ PROLACTIN
☐ GLUCOSE ☐ FAST
☐ GGT
☐ HCG, Quantitative (HCG Titer)
☐ HGB A-1-C (Glycohemoglobin)
☐ HGB ☐ HCT
☐ HBSAG (Hep B Antigen)
☐ Hepatitis B AB ☐ if post-vaccine
☐ HIV ANTIBODY
☐ IgG ☐ IgA ☐ IgM
☐ IgE
☐ IRON ☐ TIBC
☐ LDH
☐ MAGNESIUM
☐ MONO TEST
☐ PHENOBARBITAL
☐ PHOSPHORUS
☐ PLATELET COUNT
☐ POTASSIUM
☐ PREGNANCY TEST, serum
☐ PROGESTERONE
☐ PSA (Prostate Specific Antigen)
☐ PSA, Medicare Screening
☐ PROTEIN, TOTAL

☐ PROTEIN, 24 HR URINE
☐ PROTEIN ELECTROPHORESIS
☐ PROTIME (PT) ☐ if on anticoag
☐ APTT (PTT)
☐ QUAD TEST, maternal serum
☐ RHEUMATOID FACTOR
☐ RUBELLA TITER (IgG)
☐ SED RATE (ESR)
☐ SICKLE CELL SCREEN
☐ SODIUM
☐ T4 TOTAL (THYROXINE)
☐ THEOPHYLLINE
☐ TRIGLYCERIDES
☐ TSH ☐ FREE T4
☐ URIC ACID
☐ VITAMIN B12 ☐ FOLATE

MICROBIOLOGY

☐ URINALYSIS
☐ URINE CULTURE ☐ Cath ☐ Clean Catch
☐ RAPID STREP ☐ Throat Culture only
☐ STOOL: ☐ Culture
☐ C. Diff Toxin ☐ Ova & Parasites
☐ RotaviruS ☐ Giardia Antigen
☐ RSV, NASAL WASHING

OTHER TESTS / COMMENTS

☐ _____

☐

Advanced Beneficiary Notice: I have been notified by my physician/supplier that he/she believes that, in my case, Medicare is likely to deny payment for _____(test) for the following reasons: _____. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____
Signature of Patient (ABN)

FOR LABORATORY USE AT TIME OF SERVICE:

I assign any Medicaid/Medicare, other government or private insurance benefits that I am entitled to receive to Huntsville Hospital and request that said payment be made directly to the Hospital. Huntsville Hospital is authorized to release any records to public/private insurance carriers. I/we agree to pay and guarantee payment of all charges incurred for lab work.

_____
Signature of Patient or Guarantor (assigning benefits, guaranteeing payment, releasing information)

PLEASE CALL 265-2522 OR 800-278-0588 WITH ANY QUESTIONS.