



UMMC: (601) 984-2373 • UMMC Fax: (601) 815-6105

|   |                       |  |
|---|-----------------------|--|
| Patient Name:   |                       |  |
| DOB:  | SS#:                  | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Physician/Clinician:  |                       |  |
| Collector:  | Collection Date/Time: |  |
| Ordering Facility:  |                       |  |
| Specimen Source:  |                       |  |
| <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood <input type="checkbox"/> Fasting <input type="checkbox"/> Urine<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> 24 Hr Urine: Volume _____ Height _____ Weight _____ |                       |  |
| <input type="checkbox"/> STAT <input type="checkbox"/> Fax(# _____ )<br><input type="checkbox"/> Please call results to: _____  |                       |  |
| Tests denoted with * will require an appropriately completed ABN if diagnosis or testing frequency requirements do not meet current guidelines.   |                       |  |
| Other test(s), comments, special handling instructions  |                       |  |

| This section must be completed for third party billing or client will be billed.  |  |
|---|--|
| Bill to <input type="checkbox"/> Clinic <input type="checkbox"/> Insurance <input type="checkbox"/> Patient<br><b>Primary Insurance</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____<br>Network/Carrier _____<br>Policy Holder Name _____<br>Policy # _____ Group # _____<br>Address _____<br>City _____ State _____ Zip _____<br><b>Secondary Insurance</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____<br>Network/Carrier _____<br>Policy Holder Name _____<br>Policy # _____ Group # _____<br>Address _____<br>City _____ State _____ Zip _____<br><b>Guarantor</b> Self Spouse Other _____<br>Name _____ DOB ____/____/____<br>SSN _____ Phone # (____) _____<br>Address _____<br>City _____ State _____ Zip _____ |  |

| PROFILES   | ICD        | MICROBIOLOGY                                       | ICD        | CHEM/SERO/IMMUNO                                 | ICD   | CHEM/SERO/IMMUNO                                     | ICD   |
|--|------------|--|------------|--|-------|--|-------|
| <input type="checkbox"/> Basic Metabolic Panel (With Total, Calcium) | _____      | <b>Site/Source</b>                                 | _____      | <input type="checkbox"/> Amylase                 | _____ | <input type="checkbox"/> IFE, Urine                  | _____ |
| <input type="checkbox"/> Liver (Hepatic) Function Panel              | _____      | <input type="checkbox"/> Culture AFB               | _____      | <input type="checkbox"/> ANA Screen              | _____ | <input type="checkbox"/> Immunglobulin Panel         | _____ |
| <input type="checkbox"/> Renal Function Panel                        | _____      | <input type="checkbox"/> Culture Anaerobic         | _____      | <input type="checkbox"/> Anti phospholipid Panel | _____ | <input type="checkbox"/> Iron, TIBC                  | _____ |
| <input type="checkbox"/> ANA Comp Panel                              | _____      | <input type="checkbox"/> Culture Blood             | _____      | <input type="checkbox"/> Anti TPO                | _____ | <input type="checkbox"/> LH                          | _____ |
| <input type="checkbox"/> Lipid Panel*                                | _____      | <input type="checkbox"/> Culture Fungal            | _____      | <input type="checkbox"/> AST (SGOT)              | _____ | <input type="checkbox"/> Lipase                      | _____ |
| <input type="checkbox"/> Hepatitis Panel, Acute                      | _____      | <input type="checkbox"/> Culture Genital           | _____      | <input type="checkbox"/> ALT (SGPT)              | _____ | <input type="checkbox"/> Magnesium                   | _____ |
| <input type="checkbox"/> Comp Metabolic Panel                        | _____      | <input type="checkbox"/> Culture Grp B Strep       | _____      | <input type="checkbox"/> B12*                    | _____ | <input type="checkbox"/> Potassium                   | _____ |
| <b>Hematology/Coag</b>   | <b>ICD</b> | <input type="checkbox"/> Culture Herpes            | _____      | <input type="checkbox"/> BUN                     | _____ | <input type="checkbox"/> Pregnancy Test Urine        | _____ |
| <input type="checkbox"/> CBC w/ Diff                                 | _____      | <input type="checkbox"/> Culture Respiratory       | _____      | <input type="checkbox"/> CA 125                  | _____ | <input type="checkbox"/> Progesterone                | _____ |
| <input type="checkbox"/> Hemoglobin                                  | _____      | <input type="checkbox"/> NP                        | _____      | <input type="checkbox"/> CEA*                    | _____ | <input type="checkbox"/> Prolactin                   | _____ |
| <input type="checkbox"/> Hematocrit                                  | _____      | <input type="checkbox"/> Sputum                    | _____      | <input type="checkbox"/> Celiac Panel            | _____ | <input type="checkbox"/> Protein Electrophoresis     | _____ |
| <input type="checkbox"/> Sed Red (ESR)                               | _____      | <input type="checkbox"/> Other                     | _____      | <input type="checkbox"/> Cholesterol             | _____ | <input type="checkbox"/> Serum                       | _____ |
| <input type="checkbox"/> PT*   | _____      | <input type="checkbox"/> Culture Throat            | _____      | <input type="checkbox"/> Chlamydia DNA Probe*    | _____ | <input type="checkbox"/> Urine                       | _____ |
| <input type="checkbox"/> PTT   | _____      | <input type="checkbox"/> Culture Urine             | _____      | <input type="checkbox"/> Chlamydia/GC DNA Probe* | _____ | <input type="checkbox"/> PSA Diagnostic*             | _____ |
| <input type="checkbox"/> CBC-no Diff                                 | _____      | <input type="checkbox"/> Catheterized              | _____      | <input type="checkbox"/> GC DNA Probe*           | _____ | <input type="checkbox"/> PSA, Screen* (Medicare)     | _____ |
| <b>24 Hour Urines</b>  | <b>ICD</b> | <input type="checkbox"/> Clean Catch               | _____      | <input type="checkbox"/> Endocervical            | _____ | <input type="checkbox"/> Rheumatoid Factor           | _____ |
| <input type="checkbox"/> Protein                                     | _____      | <input type="checkbox"/> Indwelling Cath           | _____      | <input type="checkbox"/> Vaginal                 | _____ | <input type="checkbox"/> PTH with Calcium            | _____ |
| <input type="checkbox"/> Creatinine                                  | _____      | <input type="checkbox"/> Culture, Routine          | _____      | <input type="checkbox"/> Thin Prep Vial          | _____ | <input type="checkbox"/> RPR                         | _____ |
| <input type="checkbox"/> Creatinine Clearance                        | _____      | <input type="checkbox"/> Culture Wound             | _____      | <input type="checkbox"/> Urethral, Male          | _____ | <input type="checkbox"/> RSV                         | _____ |
| Ht. _____ in Wt. _____ lb.   |            | <input type="checkbox"/> Culture Misc              | _____      | <input type="checkbox"/> Male Urine              | _____ | <input type="checkbox"/> GGT*                        | _____ |
| Must collect and send serum creatinine for calculation               |            | <input type="checkbox"/> Strep "A" Screen          | _____      | <input type="checkbox"/> Cortisol                | _____ | <input type="checkbox"/> Thyroglobulin               | _____ |
| <b>Therapeutic Drugs</b>   | <b>ICD</b> | <b>STOOLS</b>                                      | <b>ICD</b> | <input type="checkbox"/> CK                      | _____ | <input type="checkbox"/> T4, Free*                   | _____ |
| <input type="checkbox"/> Cyclosporine                                | _____      | <input type="checkbox"/> C. difficile Toxin B, PCR | _____      | <input type="checkbox"/> Creatinine              | _____ | <input type="checkbox"/> TSH*                        | _____ |
| <input type="checkbox"/> Depakene (Valproic Acid)                    | _____      | <input type="checkbox"/> Crypto/Giardia EIA        | _____      | <input type="checkbox"/> CRP                     | _____ | <input type="checkbox"/> TSH, Reflexive*             | _____ |
| <input type="checkbox"/> Digoxin                                     | _____      | <input type="checkbox"/> Lactoferrin               | _____      | <input type="checkbox"/> Ferritin*               | _____ | <input type="checkbox"/> Testosterone                | _____ |
| <input type="checkbox"/> Dilantin                                    | _____      | <input type="checkbox"/> H. Pylori Ag              | _____      | <input type="checkbox"/> Folate*                 | _____ | <input type="checkbox"/> Testosterone, Free          | _____ |
| <input type="checkbox"/> Dilantin, Free                              | _____      | <input type="checkbox"/> Culture, Stool            | _____      | <input type="checkbox"/> FSH                     | _____ | <input type="checkbox"/> Trichomonas, PCR            | _____ |
| <input type="checkbox"/> Everolimus                                  | _____      | <input type="checkbox"/> Fecal Fat, Qualitative    | _____      | <input type="checkbox"/> Glucose*                | _____ | <input type="checkbox"/> Urine                       | _____ |
| <input type="checkbox"/> Methotrexate                                | _____      | <input type="checkbox"/> Occult Blood*             | _____      | <input type="checkbox"/> Hemoglobin A1C*         | _____ | <input type="checkbox"/> Endocervical                | _____ |
| <input type="checkbox"/> Sirolimus                                   | _____      | # Sample _____                                     |            | <input type="checkbox"/> HCG (Quant)*            | _____ | <input type="checkbox"/> Pt Collected Vaginal        | _____ |
| <input type="checkbox"/> Tacrolimus                                  | _____      | <b>URINE</b>                                       | <b>ICD</b> | <input type="checkbox"/> HCV Ab                  | _____ | <input type="checkbox"/> Triglycerides*              | _____ |
|  |            | <input type="checkbox"/> Urine Ag Strep Pneumo     | _____      | <input type="checkbox"/> Hep B Surf Ab           | _____ | <input type="checkbox"/> Urinalysis w/out Microscopy | _____ |
|  |            | <input type="checkbox"/> Urine Ag Legionella       | _____      | <input type="checkbox"/> HIV Screen              | _____ | <input type="checkbox"/> Urinalysis w/ Microscopy    | _____ |
|  |            |  |            | <input type="checkbox"/> IFE, Serum              | _____ | <input type="checkbox"/> Vitamin D, 25-Hydroxy*      | _____ |