WISCONSIN DIAGNOSTIC LABORATORIES

LABORATORY REQUEST FORM – PLEASE PRINT

Fax: 414.805.4535 | Toll-Free Fax: 877.411.0004 | Phone: 414.805.7588 | Toll-Free: 877.473.0001

FACILITY INFORMATION: (REQUIRED)

Facility Account #:		
Facility Name:	Room #:	Wing:

PATIENT INFORMATION: (REQUIRED - please provide patient's FULL and LEGAL name)

Social Security# / MRN#:	Date of Birth:	Gender: ❑ Male ❑ Female
Last Name:	First Name:	MI:
Address where specimen will be obtained (Home Health Use Only):		
Street:	Phone:	
City:	State:	Zip Code:

Homebound Status: ❑ Yes ❑ No I certify that the above patient meets the Medicare guidelines for homebound status (**sign below**).

NON-BLOOD SPECIMENS:

Date collected: (REQUIRED)	TEST(S): (REQUIRED)	ICD-10 CODE (REQUIRED TO PERFORM TEST)
Time collected: (REQUIRED)	❑ UA Only (no Culture or Sensitivities)	
Specimen Type: (REQUIRED)	❑ UA/C&S, if indicated	
❑ Urine – Voided ❑ Stool	❑ Urine Culture (no UA)	
❑ Urine – Cath ❑ Sputum	❑ Stool Culture (does not include C. diff)	
❑ Urine – Clean Catch	❑ C. diff (no Stool Culture)	
❑ Culture Swab, Sour:	❑ MRSA Screen (no Sensitivities)	
❑ Other:	❑ VRE Screen (no Sensitivities)	
❑ Other:	❑ Routine Culture (Sensitivities included)	
❑ Other:	❑ Other:	
❑ Other:	❑ Other:	

BLOOD SPECIMEN COLLECTIONS:

Line Draw: ❑ Yes ❑ No ❑ **STAT (In addition to sending, please call LTC Client Services at 414-805-7588)**

START AND END DATES MUST BE SPECIFIED. Periodic recurring orders should be started on your **N**ext **R**outine **D**raw **D**ay (NRDD). Please check the NRDD box below for labs to be started on your next routine draw day.

TESTS (NOTE: CERTAIN SCREENING TESTS MAY NOT BE COVERED BY MEDICARE):

Test(s) to be ordered	Frequency	Start Date:	NRDD	End Date	ICD-10 Code (REQUIRED TO PERFORM TEST)
		:	❑		
		:	❑		
		:	❑		
		:	❑		

ORDERING PROVIDER INFORMATION: (IMPORTANT & REQUIRED)

PRINT Last name:	**PRINT** First name:
NPI:	Credentials:
Phone:	Fax:

INSURANCE INFORMATION: (for NEW patients, complete insurance information below or send face sheet)

Medicare #:	Private Insurance:	
T-19#:	Policy #:	Group #:

SPECIFIC INSTRUCTIONS:

ORDERING PROVIDER SIGNATURE: (SIGNATURE REQUIRED)

Signature:	**Date:**	**Time:**