

# LABORATORY REQUEST FORM – PLEASE PRINT

**Note:** The medical information in this attachment has been released according to Wisconsin State Statutes 146.81 – 83, 250, 252, 51.30 and Federal Law 24 CFR. Confidentiality of this information is protected. The recipient of this information is prohibited from re-disclosing the information to any other party under these statutes. The information in this facsimile message is intended only for the personal and confidential uses of the designated recipient named above. The information is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that you have received this document in error and that any review, distribution, or copying of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately so that we can arrange for the retrieval of the original documents at no cost to you or your company.

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

<b>FACILITY INFORMATION: (REQUIRED)</b>					
Facility Account #:					
Facility Name:			Room #:	Wing:	
<b>PATIENT INFORMATION: (REQUIRED - please provide patient's FULL and LEGAL name)</b>					
Social Security# / MRN#:		Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name:		First Name:			MI:
Address where specimen will be obtained (Home Health Use Only):					
Street:				Phone:	
City:			State:	Zip Code:	
Homebound Status: <input type="checkbox"/> Yes <input type="checkbox"/> No I certify that the above patient meets the Medicare guidelines for homebound status ( <b>sign below</b> ).					
<b>NON-BLOOD SPECIMENS:</b>					
Date collected:	(REQUIRED)	TEST(S): (REQUIRED)		ICD-10 CODE (REQUIRED TO PERFORM TEST)	
Time collected:	(REQUIRED)	<input type="checkbox"/> UA Only (no Culture or Sensitivities)			
Specimen Type: (REQUIRED)		<input type="checkbox"/> UA/C&S, if indicated			
<input type="checkbox"/> Urine – Voided	<input type="checkbox"/> Stool	<input type="checkbox"/> Urine Culture (no UA)			
<input type="checkbox"/> Urine – Cath	<input type="checkbox"/> Sputum	<input type="checkbox"/> Stool Culture (does not include C. diff)			
<input type="checkbox"/> Urine – Clean Catch		<input type="checkbox"/> C. diff (no Stool Culture)			
<input type="checkbox"/> Culture Swab, Sour:		<input type="checkbox"/> MRSA Screen (no Sensitivities)			
<input type="checkbox"/> Other:		<input type="checkbox"/> VRE Screen (no Sensitivities)			
<input type="checkbox"/> Other:		<input type="checkbox"/> Routine Culture (Sensitivities included)			
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:			
<b>BLOOD SPECIMEN COLLECTIONS:</b>					
Line Draw: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> STAT (In addition to sending, please call LTC Client Services at 414-805-7588)			
<b>START AND END DATES MUST BE SPECIFIED.</b> Periodic recurring orders should be started on your <b>Next Routine Draw Day (NRDD)</b> . Please check the NRDD box below for labs to be started on your next routine draw day.					
<b>TESTS (NOTE: CERTAIN SCREENING TESTS MAY NOT BE COVERED BY MEDICARE):</b>					
Test(s) to be ordered	Frequency	Start Date:	NRDD	End Date	ICD-10 Code (REQUIRED TO PERFORM TEST)
		:	<input type="checkbox"/>		
		:	<input type="checkbox"/>		
		:	<input type="checkbox"/>		
		:	<input type="checkbox"/>		
<b>ORDERING PROVIDER INFORMATION: (IMPORTANT &amp; REQUIRED)</b>					
PRINT Last name:			PRINT First name:		
NPI:			Credentials:		
Phone:			Fax:		
<b>INSURANCE INFORMATION: (for NEW patients, complete insurance information below or send face sheet)</b>					
Medicare #:		Private Insurance:			
T-19#:	Policy #:			Group #:	
<b>SPECIFIC INSTRUCTIONS:</b>					
<b>ORDERING PROVIDER SIGNATURE: (SIGNATURE REQUIRED)</b>					
Signature:		Date:		Time:	