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: (IMMEDIATELY after collection, fax requisition AND call LTC Client Services at 414-805-7588)

**Date collected**: (REQUIRED) **Time collected**: (REQUIRED)

| **Specimen Type**: (REQUIRED) | **TEST(S)**: (REQUIRED) | | | |
|---|---|---|---|---|
| ❑ Urine – Clean Catch / Midstream Void | ❑ | Urinalysis (LAB4001) | ❑ | MRSA Screen (LAB6020) |
| ❑ Urine – Indwelling Cath | ❑ | Urinalysis w/ reflex to culture (LAB4009) | ❑ | Routine Culture (LAB6025) |
| ❑ Urine – Straight Cath | ❑ | Urine Culture (LAB6028) | ❑ | Asymptomatic COVID (LAB6138) |
| ❑ Stool | ❑ | Stool Culture (LAB6124) | ❑ | COVID NAAT (LAB6135) |
| ❑ Sputum | ❑ | C. difficile NAAT (LAB6057) | ❑ | COVID/Influenza NAAT (LAB6136) |
| ❑ Culture Swab, **Body site:** | ❑ | Fecal Occult Blood Screen (LAB6046) | ❑ | COVID/Influenza/RSV NAAT (LAB6137) |
| ❑ Viral Swab/UTM, **Body site:** | ❑ | Fecal Occult Blood Diagnostic (LAB6045) | ❑ | Other: |
| ❑ Other: | **ICD-10 CODE(S): (REQUIRED)** | | | |

## BLOOD SPECIMEN COLLECTIONS:

❑ Routine ❑ **STAT (Fax requisition AND 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) |
|---|---|---|---|---|
| | | : | | |
| | | : | | |
| | | : | | |
| | | : | | |

## ORDERING PROVIDER INFORMATION: (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:** |