

LABORATORY REQUEST FORM – PLEASE PRINT

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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 Next Routine Draw Day (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)
		:	<input type="checkbox"/>		
		:	<input type="checkbox"/>		
		:	<input type="checkbox"/>		
		:	<input type="checkbox"/>		

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: