CLIENT INFORMATION

LABQ DIAGNOSTICS
140 58th Street, Bldg. A, Ste. 3L, Brooklyn, NY 11220
Tel: 1-888-LABQ-247 (1-888-522-7247)
Fax: 718-534-5229 www.labq.com

ACCESSION NUMBER
PLACE LABEL HERE

GENERAL TEST REQUISITION

REVISED FORM — UPDATED 03/2021

COMMAND LAB FORMS 800-570-8755 EXT. 4

112793

Patient Information *(Required)*

Name (Last, First, M)_____
Address _____
City, State, Zip _____
Phone# _____
Date of Birth ____/____/____ Patient SSN _____
Gender [ ] M [ ] F Client Chart/Pt. ID# _____

Order Date ____/____/____ ☐ **STAT** ☐ Fasting _____ hrs.
Collection Date ____/____/____ **Time of Collection** ____:____ AM PM
Collector Name _____
☐ Fax Report to _____ ☐ Call Results to _____

MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)
I have read the ABN on the reverse. If Medicare denies payment, I agree to pay for the identified test(s).
X _____
Patient's Signature Date

INSURANCE INFORMATION *A clear copy of insurance card(s) front and back is required.*

[ ] Self [ ] Spouse [ ] Child [ ] Other
Insurance Name _____
Insurance ID# _____
Group#/Category # _____
Insured Name (If different than patient) _____
Insurance Address _____
Insurance City, State, Zip _____
Insurance Telephone # _____
BILL TO [ ] Patient [ ] Client [ ] Medicare [ ] Medicaid [ ] Insurance [ ] Other

DX Codes *(Required)* **List all ICD10 codes:**
[ ]_____ , [ ]_____ , [ ]_____ , [ ]_____
[ ]_____ , [ ]_____ , [ ]_____ , [ ]_____

Doctor's Signature *(Required)*
_____

COMMON PANELS

1120 ☐ **BASIC METABOLIC** SS Na, K, Cl, CO2, Creat, Ca, Gluc, BUN	1130 ☐ **COMPREHENSIVE METABOLIC** SS Na, K, Cl, CO2, Ca, Creat, Gluc, Tot. Prot., Alb, BUN, ALP, AST, ALT, Tot. Bili	1140 ☐ **HEPATIC FUNCTION** SS ALB, Tot. Prot., Tot. Bili., ALP, AST, ALT	1150 ☐ **LIPID** SS CHOL, HDL, LDLc, TRIG, vLDLc
3075 ☐ **THYROID** SS T4, TU, TSH, T3 free, T3 tot.	850 ☐ **IRON DEFICIENCY** SS Iron, TIBC, UIBC, % Sat, Ferritin, Transferrin	840 ☐ **ARTHRITIS** LV, SS CBC, ANA, ASO, ESR, RF, UA, CCP IgG Ab	1180 ☐ **ANEMIA** LV, SS CBC, Iron, TIBC, UIBC, Retic. Ct., Ferritin, vitB12, FOL, Transferrin

HEMATOLOGY		ALPHABETICAL TESTS		ALPHABETICAL TESTS		ALPHABETICAL TESTS	
372 ☐ BNP	LV	800 ☐ DHEA	SS	304 ☐ RF	SS
20 ☐ CBC w/ Diff.	LV	185 ☐ Estradiol	SS	432 ☐ Rubella IgG Ab	SS
371 ☐ D-Dimer	LV	115 ☐ Ferritin	SS	305 ☐ RPR	SS
246 ☐ ESR	LV	163 ☐ Folate	SS	133 ☐ Sodium	SS
036 ☐ PT/INR	BL	029 ☐ Fructosamine	SS	145 ☐ T3 uptake	SS
037 ☐ PTT	BL	139 ☐ FSH	SS	023 ☐ T3 free	SS
247 ☐ Reticulocyte count	LV	116 ☐ GTP (GGT)	SS	980 ☐ T3 tot	SS
B036 ☐ ABO group & Rh	PNK	118 ☐ Globulin	SS	144 ☐ T4	SS
197 ☐ AFP	SS	117 ☐ Gluc. (fasting)	GY	252 ☐ T4 free	SS
101 ☐ ALB	SS	119 ☐ Glyco (HbA1c)	LV	197 ☐ Theophylline	SS
102 ☐ ALP	SS	463 ☐ bHCG (Qty)	SS	H103 ☐ Thyroglobulin Ab	SS
106 ☐ ALT	SS	147 ☐ HCG (Qual)	SS	B033 ☐ Thyroglobulin	SS
712 ☐ Ammonia	LV	108 ☐ HDL	SS	H497 ☐ Thyroid Peroxidase Ab	SS
105 ☐ Amylase	SS	324 ☐ Hep A tot Ab	SS	121 ☐ TIBC	SS
301 ☐ ANA Screen w/rflx	SS	320 ☐ Hep B Surf Ab	SS	187 ☐ Testosterone	SS
H535 ☐ Anti-Thyroglobulin Ab	SS	B015 ☐ Hep B Core Ab	SS	131 ☐ Total Protein	SS
302 ☐ ASO	SS	319 ☐ Hep B Surf Ag	SS	146 ☐ TSH	SS
107 ☐ AST	SS	971 ☐ Hep C Vir Ab	SS	231 ☐ Transferrin	SS
113 ☐ Bilirubin Direct	SS	316 ☐ Herpes I and II IgG	SS	132 ☐ Triglycerides	SS
129 ☐ Bilirubin Total	SS	5067 ☐ HIV ½ Ab, p24 Ag*	SS	531 ☐ Troponin I	GN
678A ☐ pBN P	SS	677 ☐ Homocysteine	SS	0121 ☐ UIBC	SS
136 ☐ BUN	SS	B017 ☐ H.Pylori Ab IgG	SS	137 ☐ Uric Acid	SS
664 ☐ C3	SS	580 ☐ Human Growth Hormone	SS	NGYN ☐ Urine Cytology	UR
665 ☐ C4	SS	2924 ☐ HPV	OT	1448 ☐ Urine Drug Screen	UR
103 ☐ Calcium	SS	386 ☐ Insulin	SS	212 ☐ Urine Microalbumin	UR
684 ☐ CA125	SS	120 ☐ Iron	SS	310 ☐ Urine Pregnancy	UR
698 ☐ CA15.3	SS	123 ☐ LDH	SS	962 ☐ Valproic Acid	RE
685 ☐ CA19.9	SS	198 ☐ LDL	SS	356 ☐ Vancomycin	RE
025 ☐ CA 27.29	SS	140 ☐ LH	SS	075 ☐ Varicella Ab	SS
B10 ☐ Carbamazepine	SS	124 ☐ Lipase	SS	162 ☐ Vit. B12	SS
383 ☐ CEA	SS	709 ☐ Lithium	RE	160 ☐ Vit.D, 25-Hydroxy	SS
135 ☐ Chloride	SS	125 ☐ Magnesium	SS	**URINALYSIS**	
109 ☐ Cholesterol, Total	SS	0944 ☐ Measles Ab IgG	SS	030 ☐ Urinalysis w/ microscopic	UR
130 ☐ CO2	SS	765 ☐ Mumps Ab IgG	SS	**MICROBIOLOGY**	
495 ☐ COR	SS	777 ☐ Occult Blood	STL	605 ☐ Urine Culture	UR
110 ☐ CPK	SS	127 ☐ Phosphorus	SS	605A ☐ Blood Culture	OT
111 ☐ CKMB	SS	150 ☐ Phenobarbital	SS	604 ☐ Throat Culture	SW
112 ☐ Creatinine	SS	151 ☐ Phenytoin	SS	606 ☐ Wound Culture	SW
300 ☐ CRP	SS	134 ☐ Potassium	SS	602 ☐ Stool Culture	ST
1537 ☐ hsCRP	SS	913 ☐ Progesterone	SS	601 ☐ Genital Culture	SW
714 ☐ C-Pep	SS	181 ☐ Prolactin	SS	537 ☐ Miscellaneous Culture:	SW/OT
148 ☐ Digoxin	SS	194 ☐ PSA Free/Tot	SS		
151 ☐ Dilantin	SS	196 ☐ PSA	SS	2928 ☐ Trichomonas	UR
		787 ☐ PTH	SS		
		247 ☐ Reticulocyte count	LV		

CUSTOM PROFILES

GYN/PAP: ☐ GYN/PAP THIN-PREP
☐ VAG ☐ CERV ☐ ENDOCERV
☐ OTHER:_____
☐ **TISSUE PATHOLOGY**
SOURCE:
OTHER MEDICAL DATA:
☐ ABN BLEEDING ☐ HORMONE RX ☐ POST PARTUM
☐ PREGNANT ☐ IUD ☐ OTHER:_____
LMP _____/_____/_____
PREVIOUS SMEAR? ☐ YES ☐ NO
DATE:_____/_____/_____
PREVIOUS TEST RESULTS
FURTHER HISTORY

REQUIRES SPECIFIC DIAGNOSIS
*Please read and sign informed consent on reverse side.

BARCODE 1234567

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SS SEP	LV LAV	GY GRAY	BL BLUE	GN GREEN	RE RED	YE YELLOW	BX TISSUE	UR URINE	UA U24	UC URICLT	SW SWAB	SL SLIDE	ST STOOL	PNK PINK	OT OTHER

Version 20200313

PANELS

*PLEASE WRITE TEST CODE IN "CUSTOM PROFILES" SECTION ON FRONT

1115 **CARDIAC PANEL** TROPONIN I, CKMB (Incl. CPK), PRO-BNP hs CRP HOMOCYSTEINE	**B201** **CELIAC DISEASE PANEL** GLIADIN IGG/IGA, TTG IGG/IGA, IGA DEFICIENCY TEST INCLUDED	**820** **FERTILITY PANEL** FSH, LH PROLACTIN, TESTOSTERONE, ESTRADIOL, PROGESTERONE	**1680** **ACUTE HEPATITIS PANEL** HEP A AB IGM, HEP B CORE, HEP B SUR AG, HEP SUR AB, HEP C AB	**A121** **FOOD ALLERGY PROFILE** CLAM, CORN, EGG WHITE, CODFISH, COWS MILK, PEANUT, SHRIMP, SOYBEAN, WALNUT, WHEAT

A119 **RESPIRATORY ALLERGY PROFILE** Total IgE, D. pteronyssinus (House Mite), D. Farinae (House Mite), Cat Epithelium, Dog Epithelium, Timothy Grass, Cockroach, Cladosporium, Herbarum, Asperfillus Fumigatus, Alternaria Tenius, Box Elder/Maple, Oak, Elm, Ragweed, Common, Lamb's Quarters (Goosefoot)	**1170** **CHEM 29 PANEL** ALBUMIN, ALKALINE PHOSPHATASE, TOTAL BILIRUBIN, BUN/CREATININE RATIO, CALCIUM, CHLORIDE, CHOLESTEROL, CHOL/HDL, C02, CREATININE, GLUCOSE, HDL CHOLESTEROL, LDL/HDL RATIO, PERCENT HDL, PHOSPHORUS, POTASSIUM, AST, ALT, SODIUM, TOTAL PROTEIN, TRIGLYCERIDES, BUN, URIC ACID, GGT, LDH, IRON, GLOBULIN

Informed Consent to Perform HIV Testing

I agree to testing for HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

For pregnant women only:
In addition to the testing described above, I authorize my health care professional to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: _____ Date:_____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject:_____

Printed Name_____

ADVANCE BENEFICIARY NOTICE (ABN)
To the Beneficiary: Your physician may sometimes order laboratory testing that he or she believes to be necessary for your care, but which do es not qualify for coverage under Medicare's standards. Medicare will only pay for services that it determines to be "reasonable and necessary" based upon the diagnosis information furnished to DART MEDICAL LABORATORY by your physician. If, *under Medicare's standards*, your diagnosis does not support the testing ordered, Medicare will deny coverage. In those cases where Medicare denies coverage, the billing will be forwarded to you, and you will be responsible for the cost of the laboratory tests.
Beneficiary Agreement: I have been notified by my physician/supplier that he or she believes that, in my case, Medicare may deny payment for the services identified above. If Medicare denies payment, I agree to be personally and fully responsible for payment.