

Laboratory Requisitions

A Sentara Reference Laboratory requisition form must accompany each specimen or group of specimens for each patient. Sentara Reference Laboratory can customize test requisition forms with tests specific to your practice at no charge. To facilitate ordering of procedures in different specialty areas, several types of requisitions are available. These include our general laboratory requisition, cytology (both GYN and non-GYN)/histology requisition, a Women's Health requisition (featuring general and GYN laboratory testing on one form), nursing home requisition and a chain of custody drug screening requisition. Please be sure to use the appropriate requisition form when ordering tests. Samples of these Sentara Reference Laboratory requisitions are located at the end of this chapter.

4Medica - Internet based order entry and result retrieval

Sentara Laboratory Services offers its clients the convenience of 4Medica, the leading internet-based laboratory order entry and result retrieval system. 4Medica is a physician designed platform that facilitates the flow of information between physician practices and laboratories via its innovative, intuitive format. Among the many features include:

- Quick, accurate laboratory order entry – eliminates the need for handwriting on carbon requisition forms,
- View specimen requirements online for accurate collection procedures;
- Check validity of ICD-9 codes and if necessary, print ABN forms at time of order;
- Avoid repetitive data entry with auto fill feature;
- Easily interfaces with most practice management systems;
- Results are quickly posted, easy to read and print and always accessible online;
- Monitor patient response to treatment with instant graphs and cumulative reports;

If you are interested in employing 4Medica in your practice, please contact your Sentara Laboratory Services Sales/Service representative for a personal demonstration of 4Medica.



Laboratory Requisition Instructions

Please read the instructions carefully before using the test requisition forms. Please print in ink and bear down so that all copies are legible. We depend on you to give us complete and accurate information so that we may process your laboratory specimens quickly and ensure the best possible patient care. If you have any questions about completing a Sentara Reference Laboratory requisition, please call Client Services at (757) 388-3621 or at (800) 822-0468.

Please use the specimen identification stickers located at the top of the standard and Women's Health requisitions to label all the specimens ordered with these requisitions. Use of the specimen identification stickers **does not** replace labeling each specimen with patient name, Social Security number/Medical Record Number and date and time of collection. When preparing specimens for delivery to the laboratory, please fold each requisition in half horizontally and place it in the side pocket of the specimen bag, with the specimen tracking barcode and patient name

and insurance information at the top of the requisition showing through the transparent specimen bag. Phlebotomists and couriers read the barcode with a hand-held specimen tracking computer. This process allows Client Services to track specimens from patient draw and pickup through result. Requisitions not folded and placed in specimen bags correctly may delay specimen processing and testing.

Notes: Each specimen submitted to Sentara Reference Laboratory must be properly labeled and be accompanied by a completed Sentara laboratory requisition. Specimens submitted for testing on other commercial laboratory requisitions will not be tested. This is a laboratory compliance policy. Requisitions can be ordered by filling out a supply order form and faxing the form to 757/965-0044.

Sentara Reference Laboratory Standard Requisition

To assist with registration and billing, the Sentara Reference Laboratory requisition lists patient information horizontally on the top half of the form. Tests and panels are grouped and listed on the bottom half of the form. Additional documentation, when applicable, must accompany the requisition for select laboratory services. Samples of these additional documents are located starting on page 22.

The following information must be complete and accurate on Sentara requisitions submitted to Sentara Reference Laboratory for testing:

Patient Information

1. Patient Social Security number/Medical Record Number
2. Patient name – last name, first name and middle initial
3. Patient sex
4. Patient race (required for AFP testing and eGFR)
5. Patient date of birth
6. Patient address including city, state and zip code
7. Ordering physician's name
8. Patient chart number

Note: Anything written in chart field will be printed on patient's results report.

9. Patient phone number
10. STAT or ASAP testing selection
11. Collection date, time, initials of collector
12. Call Results To – include physician or facility and telephone number to receive results by telephone.
13. Special Instructions/Source Information when applicable – do not write in additional tests in this area, please use space provided at bottom of requisition.

Insurance and Billing Information

14. Check box to indicate Client Bill/Skilled Nursing (only if a client account exists with SRL) or Insurance billing.
15. Guarantor name
16. Guarantor date of birth – Required for billing secondary insurance
17. Guarantor relationship to patient
18. Insurance company name
19. Insurance company address
20. Insurance subscriber number
21. Insurance group number
22. Champus sponsor name
23. Champus sponsor's Social Security number

24. Champus sponsor's rank/grade and branch of service
25. Medicare number
26. Medicaid number
27. State issuing Medicaid

Diagnosis Code(s)/Reason for Testing

28. List diagnosis code(s) on lines provided. Up to 4 codes may be listed. Write corresponding 1-4 beside the test(s) being ordered on bottom half of requisition. Diagnosis codes must be submitted for medical necessity and insurance billing.

Requesting Tests

29. Mark the box for each test requested. If the test is not preprinted on the requisition, please clearly write in the test name and number in the Additional Tests area located at the bottom left of the requisition.
30. Please be sure to note patient height and weight when ordering creatinine clear test (SRL #6829)

Advanced Beneficiary Notice (ABN)

For your convenience we have marked with an asterisk (*) those tests for which Medicare may require an ABN form. We also publish laboratory ABN forms and a reference guide to Medicare's National Coverage Policies and locally approved policies to assist you with preparing ABN's when necessary. Please see the Billing chapter of this manual for details.

AFP TESTING NOTE

When ordering AFP testing with a standard requisition, a complete history must be provided on a separate AFP history form. Please call Client Services at (757) 388-3621 or at (800) 822-0468 to request a supply of these forms when needed. A sample of the AFP history form is included at the end of this chapter. Clients utilizing our Women's Health requisition can include the necessary AFP history information directly on the Women's Health requisition and do not need to submit a separate AFP history form. To request Women's Health requisitions for your office, complete a supply request form (a blank form is included in this guide or can be obtained from Client Services or your Sales/Service Representative) and fax it to (757) 965-0044.

Lead Demographics Requirements

The Virginia General Assembly passed legislation requiring laboratories to report complete demographic information for patients tested for lead concentration in blood. In order to comply with this statute, the following information must be submitted on the requisition for each patient tested for blood lead concentration: full patient name, home address, home telephone number, work telephone number (if applicable), Social Security number, date of birth and age (write in box provided for patient date of birth), race, sex, ordering physician name, physician office address and physician office phone number, insurance provider (including Medicaid number if applicable). Specimens received without this information cannot be processed, not only delaying testing, but also requiring us to call physician offices and sometimes patients to collect this information. Consumers are wary to give personal information over the phone, especially their social security number, so please submit requisitions with all required patient information completed. Taking the time to insure requisitions contain all the information required by the state will allow Sentara Reference Lab, as well as physicians, to comply with state regulations while continuing to provide high standards of customer service to our patients. If you have any questions about the state regulations, required patient information, or how to submit completed requisitions, please contact Client Services at (757) 388-3621 or toll-free at (800) 822-0468.

Sample of Sentara Laboratory Services General requisition



PROOF

0000000	0000000
0000000	0000000

SRL XXXXXXX

SRLXXXXXX

PHYSICIAN NOTIFICATION

Physician / Provider: ICD9 diagnosis code(s) must be provided for each test ordered. Only tests that you believe are appropriate for patient care should be ordered. Medicare will pay only for tests that they consider medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

SENTARA REFERENCE LABORATORY (757) 388-3621 • (800) 822-0468 • FAX (757) 388-1942

PATIENT SOCIAL SECURITY NO.	PATIENT NAME - LAST	FIRST	M.I.	SEX	RACE	DATE OF BIRTH
PATIENT ADDRESS CITY STATE ZIP			REQUESTING PHYSICIAN			
PLEASE BILL: <input type="checkbox"/> CLIENT BILL/SKILLED NURSING <input type="checkbox"/> INSURANCE INSURANCE - PROVIDE COPY OF CARD OR COMPLETE THE FOLLOWING						
GUARANTOR NAME		DATE OF BIRTH	GUARANTOR RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/> OTHER			
INSURANCE CO. NAME (IF SENTARA HEALTH MGMT GIVE PLACE OF EMPLOYMENT)						
INSURANCE CO. ADDRESS						
SUBSCRIBER NO.		GROUP NO.		PRIMARY CARE PHYSICIAN		
CHAMPUS (SPONSOR NAME)	SPONSOR'S SOC. SEC. NO.	RANK/GRADE	BRANCH		CHART NUMBER	
MEDICARE NUMBER		MEDICAID NUMBER		PATIENT PHONE NUMBER		
<input type="checkbox"/> STAT <input type="checkbox"/> ASAP RESULTS BY 5:00 PM <input type="checkbox"/> COLLECTION DATE / TIME BY						
<input type="checkbox"/> CALL RESULTS TO:						
SPECIAL INSTRUCTIONS / SOURCE INFORMATION (Do not order additional tests here, please write in space provided at bottom of form)						
DX CODE(S) REASON FOR TEST LIST DIAGNOSIS CODE ON LINES 1-4 THEN WRITE CORRESPONDING 1-4 RESIDE TEST BEING REQUESTED						
INDICATE SPECIMENS SUBMITTED: <u> LAV </u> <u> SST </u> <u> RT </u> <u> GT </u> <u> TR </u> <u> BL </u> <u> UR </u> <u> FR </u> <u> PINK </u> <u> SWAB </u> <u> PROBE </u> <u> VTM </u> <u> TECH TV </u>						

INDIVIDUAL TESTS (SST UNLESS INDICATED)				MICROBIOLOGY (Special Media Required)			
TEST	DX CODE	TEST	DX CODE	TEST	DX CODE	TEST	DX CODE
10527 AFP TUMOR MARKER*	82105	6629 CREATININE CLEAR HT WT	82575	6606 POTASSIUM	84132	SOURCE URINE CULTURE	85113
10111 AFP MATERNAL	82105	8036 C-REACTIVE PROTEIN	86140	8754 PROT ELECTRO**	84185	2502 CLEAR CATCH 1	87084
10112 AFP TRIPLE SCREEN	82105	7125 DIOXIN*	80182	11051 PSA DIAGNOSTIC*	84153	SOURCE TBG/ST	
10113 AFP Tests (Quad)	82105	14020 DIRECT ANTIGLOBULIN TEST	86680	1251 PT w/ INR * - BLUE	80103	1125 BARD GROUP 4 STRIP SCREEN	87861
6608 ALBUMIN	82040	7130 FERRITIN*	82728	10770 SWEAT/IOD FACTOR	86431	86610 2011 Strip A Culture	87581
6614 ALK PHOSPHATASE	84075	10631 FOLATE / VIT B12	82748	8110 RPR	86592	2631 STRIPA CULTURE	87521
6809 AMYLASE	82150	8406 HGB A1c* -LAV	82607	8110 RPR	86592	16165 BARDIA EA	87529
8017 ANA SCREEN	86038	10037 HGB Elect** -LAV	83020	6610 SED RATE -LAV	86781	2843 C DIFFICILE TOIN	87524
7105 BETA HCG SERUM	84702	8413 HIV	86701	5907 SGT (AST)	86781	2770 C & P	87513
6616 BILIRUBIN DIRECT	82348	8413 HIV	86689	6630 SGT (ALT)	86782	16246 BTDOL CULTURE (primary)	87461
6635 BILIRUBIN INDIRECT	82347	8413 HIV	86689	6630 SGT (ALT)	84460	15235 SWASTON	87467
6615 BILIRUBIN TOTAL	82347	8413 HIV	86689	6630 SGT (ALT)	84460	2651 CAMPUS BACTER	87526
6602 BUN	84620	8413 HIV	86689	6630 SGT (ALT)	84460	12240 BARDIA VENTIL	87526
6619 CALCIUM	82310	8413 HIV	86689	6630 SGT (ALT)	84460	SOURCE BARDIA (Special Media)	
6608 CARBON DIOXIDE	82374	8413 HIV	86689	6630 SGT (ALT)	84460	13718 COCHLYTOAMPLIFIED	87461
1001 CBC W/ DIFF -LAV	86025	8413 HIV	86689	6630 SGT (ALT)	84460	CEPRICAL	87501
12100 CBC W/0 DIFF -LAV	86027	8413 HIV	86689	6630 SGT (ALT)	84460	CEPRICAL	87501
5080 CD4 w/ ABS. LYM -YEL-LAV	86381	11000 LIPID INITIAL*	84465	6704 ELECTROLYTES	80051	2660 ROUTINE GENERAL CULTURE	87501
7110 CEA	82378	11001 LIPID COMPLETE* FAST	80061	6707 BASIC PANEL (BMP)	80048	16159 GROUP B STREP CULTURE	87579
6607 CHLORIDE	82436	8895 MAGNESIUM*	83735	10032 COMP. PANEL (CMP)	80063	3663 GROUP B STREP CULTURE	87579
6617 CHOLESTEROL*	82465	8895 MAGNESIUM*	83735	10031 HEP FUNC PAN (LFT)	80076	SOURCE	
6611 CK	82590	7950 INHENTON/DIANTIN	80185	1007 PRENATAL - (HSA, LGA, BPD)	80055	ADDITIONAL TESTING	
6603 CREATININE	82585	8620 PHOSPHORUS	84100	11050 RENAL FUNCTION PANEL	80069	2750 AFP CULTURE & SWEAT	87116

ADDITIONAL TESTS (include diagnosis code):

2510 BLOOD CULTURE	87516
2883 VIRAL COMPREHENSIVE	87526
16004 WOUND CULTURE & GRAM STAIN	87526
2711 FUNGUS CULTURE	87526
2630 RESPIRATORY CULTURE	87579
ROUTINE CULTURE	87526

* Advanced Beneficiary Notification For Medicare Patients May Be Necessary.
** Interpretive Tests Will Have A Separate Professional Component Billed.

SEND WHITE COPY TO SENTARA

FACE PART 1: 1ST COLOR 10%, 60% SCREENS; 2ND COLOR 5% SCREEN; YELLOW INDICATES SPOT VARNISHES

Sample of Sentara Laboratory Services Cytology/Histology



BAPXXXXXX

LABEL POSITION
PART 1 ONLY



BAPXXXXXX

PHYSICIAN NOTIFICATION
Physician / Provider: ICD9 diagnosis code(s) must be provided for each test ordered. Only tests that you believe are appropriate for patient care should be ordered. Medicare will pay only for tests that they consider medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

SENTARA REFERENCE LABORATORY (757) 388-3621 • (800) 822-0468 • FAX (757) 388-1942

PATIENT SOCIAL SECURITY NO.		PATIENT NAME - LAST		FIRST	M.I.	SEX	RACE	DATE OF BIRTH
PATIENT ADDRESS				CITY	STATE	ZIP	REQUESTING PHYSICIAN	
PLEASE BILL		<input type="checkbox"/> CLIENT BILL/SKILLED NURSING		<input type="checkbox"/> INSURANCE				
INSURANCE - PROVIDE COPY OF CARD OR COMPLETE THE FOLLOWING								
GUARANTOR NAME		DATE OF BIRTH	GUARANTOR RELATIONSHIP					
			<input type="checkbox"/> SELF	<input type="checkbox"/> DEPENDENT CHILD				
			<input type="checkbox"/> SPOUSE	<input type="checkbox"/> OTHER				
INSURANCE CO. NAME (IF SENTARA HEALTH MGMT GIVE PLACE OF EMPLOYMENT)								
INSURANCE CO. ADDRESS								
SUBSCRIBER NO.				GROUP NO.				
CHAMPUS (SPONSOR NAME)		SPONSOR'S SOC. SEC. NO.	RANK/GRADE	BRANCH	CHART NUMBER	PATIENT PHONE NUMBER		
MEDICARE NUMBER		MEDICAID NUMBER		COLLECTION DATE	TIME	BY		
<input type="checkbox"/> Medicare Secondary Info Provided		STATE		CLINICAL HISTORY - REQUIRED FOR ALL HISTOLOGY AND/OR NON-GYN CYTOLOGY SPECIMENS				
<input type="checkbox"/> Medicare Secondary Payor Info on File in Physician Office		HISTORY/PERTINENT CLINICAL FINDINGS						
LIST DIAGNOSIS (REASON FOR TEST)		PREVIOUS BIOPSY OR TUMOR Dx <input type="checkbox"/> YES <input type="checkbox"/> NO SITE AND TYPE OF TUMOR <input type="checkbox"/> CHEMO/RADIATION Type: _____						
SPECIAL INSTRUCTIONS:				SURGICAL/CYTO # AND DATE(S)				

FOLD HERE

PERF

GYN CYTOLOGY - PAP SMEAR INFORMATION BELOW MUST BE COMPLETED Write Patient's Name in Pencil on ALL Slides # SLIDES

LAST MENSTRUAL PERIOD _____ SOURCE: CERVICAL/ENDO VAGINAL VULVAR OTHER (SPECIFY) _____ ROUTINE PAP DIAGNOSTIC PAP

Correlate with appropriate & available cytology or histology <input type="checkbox"/> THIN PREP PAP 18990 <input type="checkbox"/> THIN PREP PAP WHPV IF ASCUS 87621 <input type="checkbox"/> THIN PREP PAP WHPV NOW (HPV PERFORMED REGARDLESS OF PAP RESULT) <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____	CONVENTIONAL PAP CPT 88164 18871 <input type="checkbox"/> HISTOLOGY SPECIMEN ALSO SUBMITTED	CLINICAL HISTORY <input type="checkbox"/> HIGH RISK CERVICAL CANCER <input type="checkbox"/> BCP'S <input type="checkbox"/> IUD <input type="checkbox"/> PREG. _____ WKS. <input type="checkbox"/> POST PARTUM _____ WKS.	PERIMENOPAUSAL POSTMENOPAUSAL HYSTERECTOMY DATE: _____ HORMONAL RX TYPE: _____	ABNORMALS ARE REVIEWED BY A PATHOLOGIST. TESTS WILL HAVE A SEPARATE PROFESSIONAL COMPONENT BILLED (86141).
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PREVIOUS TREATMENT PREVIOUS ABNORMAL SMEAR INTERPRETED AT NON-SENTARA LAB
 NONE SURG. BIOPSY FOR INFECTION
 PREVIOUS TUMOR Dx RADIATION CHEMO Rx

DESCRIPTION/ DATES/RESULTS/ NUMBERS _____

HISTOLOGY/SURGICAL PATHOLOGY SPECIMENS MUST PROVIDE CLINICAL HISTORY ABOVE (If GYN specimen please provide info under GYN CYTOLOGY)

List Tissue Specimens 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

NON-GYN CYTOLOGY MUST PROVIDE CLINICAL HISTORY ABOVE Write Patient's Name in Pencil on ALL Slides

<input type="checkbox"/> CORRELATE WITH APPROPRIATE AND AVAILABLE CYTOLOGY OR HISTOLOGY TESTS WILL HAVE A SEPARATE PROFESSIONAL COMPONENT BILLED (86141)	BODY CAVITY FLUIDS <input type="checkbox"/> PLEURAL <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> PERICARDIAL <input type="checkbox"/> PERITONEAL Specify: _____ <input type="checkbox"/> PELVIC WASHING Site _____ <input type="checkbox"/> CSF (CEREBROSPINAL FLUID)	URINE <input type="checkbox"/> VOIDED <input type="checkbox"/> CATH <input type="checkbox"/> BLADDER WASH WASH <input type="checkbox"/> URETER } <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> PELVIS } BRUSH <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> ILEAL CONDUIT <input type="checkbox"/> REFLEX FISH IF ATYPICAL Site _____	GASTRO INTESTINAL <input type="checkbox"/> COLON BRUSHING <input type="checkbox"/> ESOPHAGEAL BRUSHING <input type="checkbox"/> STOMACH BRUSHING <input type="checkbox"/> OTHER BRUSHING - OTHER	RESPIRATORY <input type="checkbox"/> SPUTUM <input type="checkbox"/> BRONCH BRUSH <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BRONCH WASH <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> BRONCH LAVAGE <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> GMS (Silver Stain) Site _____	FNA <input type="checkbox"/> SOLID <input type="checkbox"/> CYST Site _____ # OF SLIDES <input type="checkbox"/> AIR DRIED <input type="checkbox"/> FIXED <input type="checkbox"/> MATERIAL FOR CELL BLOCK <input type="checkbox"/> NIPPLE SMEAR <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> TZANCK SMEAR Site _____ <input type="checkbox"/> OTHER SMEAR Site _____
	DO NOT WRITE IN SPACE BELOW THIS LINE				



LAB REQUEST COPY

FACE 1; SCREENS 10%

8610005068
8610005068 823007 R.R. Donnelley, All rights reserved. -0687
CHR1 B 1106

Sample of Sentara Laboratory Services Women's Health requisition



Apply Barcode Labels Ending with "G" for GYN Cytology Specimens



XXXXXXX



PHYSICIAN NOTIFICATION
 Physician / Provider: ICD9 diagnosis code(s) must be provided for each test ordered. Only tests that you believe are appropriate for patient care should be ordered. Medicare will pay only for tests that they consider medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

SENTARA REFERENCE LABORATORY (757) 668-3621 • (800) 822-0468 • FAX (757) 668-1942

PATIENT SOCIAL SECURITY NO. _____ PATIENT NAME - LAST FIRST M.I. SEX RACE DATE OF BIRTH

PATIENT ADDRESS CITY STATE ZIP REQUESTING PHYSICIAN

PLEASE CLIENT BILL INSURANCE PART "A" MEDICARE

INSURANCE: PROVIDE COPY OF CARD OR COMPLETE THE FOLLOWING

GUARANTOR NAME GUARANTOR RELATIONSHIP
 SELF DEPENDENT CHILD
 SPOUSE OTHER

INSURANCE CO. NAME (IF SENTARA HEALTH MGMT GIVE PLACE OF EMPLOYMENT)

INSURANCE CO. ADDRESS

SUBSCRIBER NO. GROUP NO.

CHAMPUS (SPONSOR NAME) SPONSOR'S SOC. SEC. NO. RANK/GRADE BRANCH CHART NUMBER PATIENT PHONE NUMBER

MEDICARE NUMBER MEDICAID NUMBER STATE

STAT CALL RESULTS TO: _____ COLLECTION DATE TIME BY

SPECIAL INSTRUCTIONS:

DX CODE(S) REASON FOR TEST LIST DIAGNOSIS CODE ON LINES 1 - 4 → THEN WRITE CORRESPONDING 1 - 4 BESIDE TEST BEING REQUESTED

1 _____ 2 _____ 3 _____ 4 _____

INDICATE SPECIMENS SUBMITTED LAV SST RT GT TR BL UR FB PINK SWAB PROBE VTM TECH TV

GYN CYTOLOGY - PAP SMEAR INFORMATION BELOW MUST BE COMPLETED Write Patient's Name in Pencil on ALL Slides # SLIDES

LAST MENSTRUAL PERIOD SOURCE CERVICAL VAG CUFF LAT VAG WALL MATURATION INDEX BIOPSY W / SMEAR

Correlate with appropriate & available cytology or histology

LIQUID BASED PAP #8148 LIQUID BASED PAP #8142 CONVENTIONAL PAP #8144 HIGH RISK CERVICAL CANCER POSTMENOPAUSAL

as HPV HIGH RISK #7521 / ASCUS SCREENING 1891 SCREENING 1891 PREG. 1891 DATE

SCREENING 1891 FOLLOW UP / DIAGNOSTIC 1891 FOLLOW UP / DIAGNOSTIC 1891 POST PARTUM _____ WKL. MENORRHAL Rx

FOLLOW UP / DIAGNOSTIC 1891 PERIMENOPAUSAL TYPE _____

PREVIOUS PREVIOUS ABNORMAL SMEAR INTERPRETED AT NON-SENTARA LAB DESCRIPTION/ DATES/RESULTS/ NUMBERS

TREATMENT NONE SURG BIOPSY FOR INFECTION CHEMO Rx

PREVIOUS TUMOR Dx RADIATION CHEMO Rx

TEST	DX CODE	TEST	DX CODE	TEST	DX CODE	TEST	DX CODE
10111 <input type="checkbox"/> AFP Maternal*	82105	8548 <input type="checkbox"/> Urinocyl	82870	12055 <input type="checkbox"/> HIV P24*	87950	8852 <input type="checkbox"/> 14 Pna	84439
10113 <input type="checkbox"/> AFP Tetra* (Quad)	MJJI	7925 <input type="checkbox"/> Urinod Free	82877	13144 <input type="checkbox"/> HPV Swab High Risk	87621*	1482 <input type="checkbox"/> 2500/astone	84433
82106 82877 84702 85620		8350 <input type="checkbox"/> Estrogen Fractions Urine	82870	13145 <input type="checkbox"/> HPV Swab Low / High Risk	87621x2	15439 <input type="checkbox"/> 2500/astone Free	84432
10112 <input type="checkbox"/> AFP Triple*	MJJI	1259 <input type="checkbox"/> Factor V Leiden	85307	8677 <input type="checkbox"/> Iron Sat*	89540*	15705 <input type="checkbox"/> Triaxid Cascade*	84443
82106 82877 84702		8240 <input type="checkbox"/> Fetal Fibroectin	82731	11021 <input type="checkbox"/> Lipid Complete*	80061*	1581 <input type="checkbox"/> TSH*	84443
8220 <input type="checkbox"/> AFAP	82108	7140 <input type="checkbox"/> FSH	83001	11020 <input type="checkbox"/> Lipid Initial*	82465	4607 <input type="checkbox"/> Type A Screen	MJJI
8639 <input type="checkbox"/> Anticardiolipin Iga Ig2 IgM	35147/33	87490 <input type="checkbox"/> GCChlamydia DNA Probe	87490	8231 <input type="checkbox"/> Lipid Profile 16/8	80718*	17500 <input type="checkbox"/> Urinalysis	83203
7116 <input type="checkbox"/> Beta HCG	82106	87590 <input type="checkbox"/> HIV 1/2	87590	11950 <input type="checkbox"/> Lipid Profile VAP	80716	2600 <input type="checkbox"/> Urine Culture*	87299
2531 <input type="checkbox"/> Beta Strip Group A Culture	87075	87226 <input type="checkbox"/> GC DNA Probe	87075		84511	PANELS <input type="checkbox"/> Basic Panel (BMP) <input type="checkbox"/> dx code	
15193 <input type="checkbox"/> Beta Strip Group B Culture	87075	2950 <input type="checkbox"/> Genital Culture	87075		83520	10032 <input type="checkbox"/> Comp. Panel (CMP)	85063
<input type="checkbox"/> Patient is allergic to penicillin		10256 <input type="checkbox"/> Glucosa 1 hour	82025	8839 <input type="checkbox"/> Lipoprotein (a)	85613	10031 <input type="checkbox"/> Hep. Func. Pan (LFT)	85061
8036 <input type="checkbox"/> Carbon CRP	86140	6601 <input type="checkbox"/> Glucose	82647	1259 <input type="checkbox"/> Lupus Anticoagulant Screen	84703	10027 <input type="checkbox"/> Electrolytes	85061
1001 <input type="checkbox"/> CBC w/DIRI	86025	11340 <input type="checkbox"/> GTT 3 hour	82951	6158 <input type="checkbox"/> Pregnancy Test Serum	84703	10021 <input type="checkbox"/> Hep. Func. Pan (LFT)	85076
12105 <input type="checkbox"/> CBC w/o DIRI	86027	8426 <input type="checkbox"/> Hemoglobin A ^{1c}	83036	6157 <input type="checkbox"/> Pregnancy Test Urine	84703	10027 <input type="checkbox"/> Prenatal	85065
8729 <input type="checkbox"/> Chlamydia DNA Probe	87490	2942 <input type="checkbox"/> Herpes Culture	87254	8556 <input type="checkbox"/> Progesterone Serum	84144	11032 <input type="checkbox"/> Renal Function Panel	85069
01604 <input type="checkbox"/> Chromosome analysis, amniotic fluid	86271x5	8419 <input type="checkbox"/> HIV 1*	86751	6527 <input type="checkbox"/> Protein 24 hour urine	84156		
		13155 <input type="checkbox"/> HIV 2*	86732	8110 <input type="checkbox"/> RPR*	85592		

PLEASE COMPLETE THE FOLLOWING FOR CHROMOSOME, AFP MATERNAL, TETRA (QUAD), AND TRIPLE TESTING.

MATERNAL WEIGHT: _____ WEEKS GESTATION: _____ ULTRA SOUND: _____ PHYSICAL EXAM: _____ LMP: _____ EDC: _____

IS PATIENT DIABETIC: YES NO INSULIN DEPENDENT: YES NO IS THIS A TWIN PREGNANCY?: YES NO RACE: _____

CONDITION OF AMNIOTIC FLUID: CLEAR BLOODY

G _____ P _____ S _____ T _____

INDICATIONS FOR AMNIOCENTESIS: MATERNAL AGE HISTORY OF NEURAL TUBE DEFECTS ABNORMAL SERUM SCREEN RECURRENT PREGNANCY LOSS

OTHER: _____

FNA SOLID CYST SITE _____ AIR DRIED _____ FIXED _____

OF SLIDES _____

MATERIAL FOR CELL BLOCK NIPPLE SMEAR R L TZANCK SMEAR SITE _____ OTHER SMEAR SITE _____



*Advanced Beneficiary Notification For Medicare Patients May Be Necessary.
 **Interpretive Tests Will Have A Separate Professional Component Billed.

FACE - PART 1 OF 3 - LINES SCREENED 20% - BOXES SCREENED 10%

Sample of Sentara Laboratory Services Nursing Home



MAGENTA TO SHOW MIDAX POSITION OF #ING & BARCODE POSITION

NHM XXXXXX C

LABEL POSITION
PART 1 ONLY



N H M X X X X X X C

PHYSICIAN NOTIFICATION

Physician / Provider: ICD9 diagnosis code(s) must be provided for each test ordered. Only tests that you believe are appropriate for patient care should be ordered. Medicare will pay only for tests that they consider medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

SENTARA REFERENCE LABORATORY (757) 388-3621 • (800) 388-0468 • FAX (757) 388-1942

PATIENT SOCIAL SECURITY NO.		PATIENT NAME - LAST		FIRST	M.I.	SEX	RACE	DATE OF BIRTH
PATIENT ADDRESS				CITY	STATE	ZIP	REQUESTING PHYSICIAN	
PLEASE <input type="checkbox"/> CLIENT BILL/SKILLED NURSING <input type="checkbox"/> INSURANCE								
INSURANCE - PROVIDE COPY OF CARD OR COMPLETE THE FOLLOWING								
GUARANTOR NAME		DATE OF BIRTH	GUARANTOR RELATIONSHIP					
			SELF <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/>					
			SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/>					
INSURANCE CO. NAME (IF SENTARA HEALTH MGMT GIVE PLACE OF EMPLOYMENT)								
INSURANCE CO. ADDRESS								
SUBSCRIBER NO.			GROUP NO.					
CHAMPUS (SPONSOR NAME)	SPONSOR'S SOC. SEC. NO.	RANK/GRADE	BRANCH	CHART NUMBER	PATIENT PHONE NUMBER			
MEDICARE NUMBER		MEDICAID NUMBER						
<input type="checkbox"/> Medicare Secondary Info Provided		STATE						
<input type="checkbox"/> Medicare Secondary Payor Info on File in Physician Office		<input type="checkbox"/> CALL RESULTS TO:						
DX CODE(S) REASON FOR TEST		SPECIAL INSTRUCTIONS/SOURCE INFORMATION:						
LIST DIAGNOSIS CODE ON LINES 1 - 4 →		1	2	3	4			
THEN WRITE CORRESPONDING 1 - 4								
BESIDE TEST BEING REQUESTED								
INDICATE SPECIMENS SUBMITTED								
LAV	SST	RT	GT	TR	BL	UR	FR	PINK
SWAB	PROBE	VTM	TECH TV					

Profiles	6603 <input type="checkbox"/> Creatinine Serum	7012 <input type="checkbox"/> Prealbumin	Microbiology
6707 <input type="checkbox"/> BMP	7975 <input type="checkbox"/> Depakote	6610 <input type="checkbox"/> Protein Total	2711 <input type="checkbox"/> Fungus culture
10032 <input type="checkbox"/> CMP	7125 <input type="checkbox"/> Digoxin*	11051 <input type="checkbox"/> PSA Screening	Source:
6704 <input type="checkbox"/> Electrolytes	7950 <input type="checkbox"/> Dilantin (Phenytoin)	6056 <input type="checkbox"/> PTH	2880 <input type="checkbox"/> Viral comprehensive
10031 <input type="checkbox"/> Hepatic Function Panel	1022 <input type="checkbox"/> ESR	1251 <input type="checkbox"/> PT*	Source:
11001 <input type="checkbox"/> Lipid Complete Panel*	7130 <input type="checkbox"/> Ferritin*	1221 <input type="checkbox"/> PTT	2750 <input type="checkbox"/> AFB Culture
Individual Tests	10631 <input type="checkbox"/> Folate/B12	6613 <input type="checkbox"/> SGOT (AST)	Source:
6609 <input type="checkbox"/> Albumin	7136 <input type="checkbox"/> Folic Acid	6922 <input type="checkbox"/> SGPT (ALT)	2040 <input type="checkbox"/> Fecal WBC's
6614 <input type="checkbox"/> Alkaline Phosphatase	8662 <input type="checkbox"/> Free T4	6605 <input type="checkbox"/> Sodium	2943 <input type="checkbox"/> Clostridium Difficile Toxin
10552 <input type="checkbox"/> Amikacin Peak	10547 <input type="checkbox"/> Gentamicin Peak	7235 <input type="checkbox"/> T4 Total	10074 <input type="checkbox"/> Occult Blood Stool 1-3 Spec
10551 <input type="checkbox"/> Amikacin Trough	10548 <input type="checkbox"/> Gentamicin Trough	7960 <input type="checkbox"/> Theophylline	2510 <input type="checkbox"/> Culture Blood
6205 <input type="checkbox"/> Ammonia	6601 <input type="checkbox"/> Glucose	10550 <input type="checkbox"/> Tobramycin Peak	2521 <input type="checkbox"/> Culture Eye
6809 <input type="checkbox"/> Amylase	6870 <input type="checkbox"/> HDL	10549 <input type="checkbox"/> Tobramycin Trough	2630 <input type="checkbox"/> Culture Lower Resp
6615 <input type="checkbox"/> Bilirubin Total	1004 <input type="checkbox"/> Hematocrit	6930 <input type="checkbox"/> Triglycerides	<input type="checkbox"/> Culture Stool
11850 <input type="checkbox"/> BNP	1003 <input type="checkbox"/> Hemoglobin	7250 <input type="checkbox"/> TSH*	18246 <input type="checkbox"/> Enterics
6602 <input type="checkbox"/> BUN	8406 <input type="checkbox"/> Hemoglobin A1C*	17500 <input type="checkbox"/> Urinalysis	2651 <input type="checkbox"/> Campylobacter
6619 <input type="checkbox"/> Calcium	1002 <input type="checkbox"/> Hgb & Hct	7975 <input type="checkbox"/> Valproic Acid	16335 <input type="checkbox"/> Shigella
7905 <input type="checkbox"/> Carbamazepine (Tegretol)	10850 <input type="checkbox"/> Ionized CA	10545 <input type="checkbox"/> Vancomycin Peak	2631 <input type="checkbox"/> Strep A Culture (Throat)
6608 <input type="checkbox"/> Carbon Dioxide	6675 <input type="checkbox"/> Iron Serum*	10546 <input type="checkbox"/> Vancomycin Trough	2600 <input type="checkbox"/> Culture Urine*
1001 <input type="checkbox"/> CBC/Diff LAV	10682 <input type="checkbox"/> Iron Binding Capacity*	7255 <input type="checkbox"/> Vitamin B12	<input type="checkbox"/> Clean catch
12100 <input type="checkbox"/> CBC w/o Diff LAV	6895 <input type="checkbox"/> Magnesium*	8713 <input type="checkbox"/> Vitamin D	<input type="checkbox"/> Catheter
6607 <input type="checkbox"/> Chloride	7738 <input type="checkbox"/> Phenobarbital	1005 <input type="checkbox"/> WBC	18004 <input type="checkbox"/> Culture Wound
6617 <input type="checkbox"/> Cholesterol*	6620 <input type="checkbox"/> Phosphorus		Source:
	6606 <input type="checkbox"/> Potassium Blood		1126 <input type="checkbox"/> Rapid Strep
			<input type="checkbox"/> If negative, order Strep A (#2631)
			Routine Culture.
			Source _____
			Additional:
8800 <input type="checkbox"/> Draw Fee	19350 <input type="checkbox"/> Trav Fee/350	9999 <input type="checkbox"/> Travel Fee/Q- Qty _____	
*Advance Beneficiary Notification	For Medicare Patients May be Needed		



GLR3

* Advanced Beneficiary Notification For Medicare Patients May Be Necessary.
** Interpretive Tests Will Have A Separate Professional Component Billed.

SEND WHITE COPY TO SENTARA

FACE 1 SCREEN 10%

Sample of Sentara Laboratory Services Chain of Custody requisition



FORENSIC DRUG TESTING CUSTODY AND CONTROL FORM



Laboratory Services
600 Gresham Drive
Norfolk, VA 23507
(757) 668-3621 - Phone
(800) 822-0468 - Toll Free
(757) 668-1942 - Fax

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE LAB ACCESSION NO. _____

<p>A. Employer Name, Address, I.D. No. _____</p>	<p>B. MRO Name, Address, Phone and Fax No. _____</p>
<p>C. Donor SSN or Employee I.D. No. _____</p>	
<p>D. Donor Name: Last: _____ First: _____</p>	
<p>E. Donor ID Verified: <input type="checkbox"/> Photo ID <input type="checkbox"/> Emp. Rep. _____ <input type="checkbox"/> Other</p>	
<p>F. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post-Accident <input type="checkbox"/> Promotion <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____</p>	
<p>G. Drug Tests to be Performed: NOT FOR FEDERAL TESTING</p>	
<p>H. Collection Site Name: _____ Collection Site Code: _____ Address: _____ Collector Phone No.: _____ City, State, and Zip: _____ Collector Fax No.: _____</p>	

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100°F? <input type="checkbox"/> Yes <input type="checkbox"/> No (Enter Remark) _____	Specimen Collection: <input type="checkbox"/> Single <input type="checkbox"/> None Provided (Enter Remark) _____	<input type="checkbox"/> Observed (Enter Remark) _____
REMARKS _____		

STEP 3: Collector affixes bottle seal to bottle. Collector dates seal. Donor initials seal. Donor completes STEP 5.
STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified on this form was collected, labeled, sealed, and released to the delivery service noted in accordance with applicable requirements.

<p><input checked="" type="checkbox"/> _____ Signature of Collector <small>(Print Collector's Name (First, MI, Last))</small></p>	<p>Time of Collection _____ AM/PM Date (Mo./Day/Yr) _____</p>	<p>SPECIMEN BOTTLE RELEASED TO: <input type="checkbox"/> Sentara Courier <input type="checkbox"/> FedEx <input type="checkbox"/> Airborne <input type="checkbox"/> Other _____ Name of Delivery Service Transferring Specimen to Lab _____</p>
<p>RECEIVED AT LAB: <input checked="" type="checkbox"/> _____ Signature of Accessioner <small>(Print Accessioner's Name (First, MI, Last))</small></p>	<p>Specimen Bottle Seal Intact <input type="checkbox"/> Yes <input type="checkbox"/> No (Enter Remark) _____</p>	<p>SPECIMEN Aliquot released to _____ for confirmation of _____ Date _____</p>

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information and numbers provided on this form and on the label affixed to each specimen bottle is correct.

<p><input checked="" type="checkbox"/> _____ Signature of Donor</p>	<p>_____ <small>(PRINT) Donor's Name (First, MI, Last)</small></p>	<p>_____ Date (Mo./Day/Yr)</p>
<p>Daytime Phone No. () _____</p>	<p>Evening Phone No. () _____</p>	<p>Date of Birth: _____ Mo. Day Yr.</p>

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

SH-4420-20-004 (1/04)



SH-4420-20-004

COPY 1 - LABORATORY

Sentara Laboratory Services Custom Requisition



GEN **XXXXXX** C

LABEL POSITION
PART 1 (ONE) ONLY



* GEN XXXXXX C *

PHYSICIAN NOTIFICATION
Physician / Provider: ICD9 diagnosis code(s) must be provided for each test ordered. Only tests that you believe are appropriate for patient care should be ordered. Medicare will pay only for tests that they consider medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

SENTARA REFERENCE LABORATORY (757) 668-3621 • (800) 822-0466 • FAX (757) 668-1942

PATIENT SOCIAL SECURITY NO.		PATIENT NAME - LAST		FIRST	M.I.	SEX	RACE	DATE OF BIRTH
PATIENT ADDRESS			CITY	STATE	ZIP	REQUESTING PHYSICIAN		
PLEASE BILL <input type="checkbox"/> CLIENT BILL/SKILLED NURSING <input type="checkbox"/> INSURANCE INSURANCE - PROVIDE COPY OF CARD OR COMPLETE THE FOLLOWING								
GUARANTOR NAME		DATE OF BIRTH	GUARANTOR RELATIONSHIP					
			<input type="checkbox"/> SELF <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER					
INSURANCE CO. NAME (IF SENTARA HEALTH MGMT GIVE PLACE OF EMPLOYMENT)								
INSURANCE CO. ADDRESS								
SUBSCRIBER NO.			GROUP NO.					
CHAMPUS (SPONSOR NAME)	SPONSOR'S SOC. SEC. NO.	RANK/GRADE	BRANCH	CHART NUMBER	PATIENT PHONE NUMBER			
MEDICARE NUMBER		MEDICAID NUMBER			STATE			
<input checked="" type="checkbox"/> Medicare Secondary Info Provided <input checked="" type="checkbox"/> Medicare Secondary Payor Info on File in Physician Office								
DX CODE(S) REASON FOR TEST LIST DIAGNOSIS CODE ON LINES 1 - 4 -- 1 3 THEN WRITE CORRESPONDING 1 - 4 BESIDE TEST BEING REQUESTED 2 4								
INDICATE SPECIMENS SUBMITTED LAV SST RT GT TR BL UR FR PINK SWAB PROBE VTM TECH TV								

(PERF)

(PERF)

FOLD
HERE



GLR3

* Advanced Beneficiary Notification For Medicare Patients May Be Necessary.
 ** Interpretive Tests Will Have A Separate Professional Component Billed.
SEND WHITE COPY TO SENTARA

FACE 1; SCREEN 10%

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