

**SPECIALTY
OUTPATIENT
LABORATORY
ORDER**

PATIENT LABEL

Completed requests should be faxed to:
Non-Surgical Patient: (414) 266-2597, Surgical Patient: (414) 266-3378

Shaded areas indicate required information

Patient Name: _____			Medical Record #: _____		
(Last)	(First)	(MI)	(If known)		
Visit #: _____	Gender: <input type="checkbox"/> Male	Date of Birth: _____	Order Date: _____ / _____ / _____	Time: _____	
(If known)	<input type="checkbox"/> Female		Month / Day / Year		

Providers/Physician Offices: An important message from Children's Hospital of Wisconsin

Children's Hospital of Wisconsin would like to remind providers that we will not accept diagnosis(es) that include the terms "probable", "possible", "suspected", "rule out", "questionable" when ordering diagnostic services for your patient. Instead, Children's Hospital of Wisconsin requires that you document the patient's signs & symptoms to the highest degree of specificity known.

This should include signs and symptoms, abnormal test results or other reasons for the tests.

Diagnosis(es) or Signs/Symptoms: _____	
Additional Clinical Instructions: _____	
PMD Name _____	
Ordering Provider Name (please print) _____	Telephone Number: _____
Provider Signature: _____	Date: _____

BLOOD

- | | |
|--|--|
| <input type="checkbox"/> 1,25 Dihydroxy Vitamin D | <input type="checkbox"/> DHEA Sulfate |
| <input type="checkbox"/> 17 OH Progesterone | <input type="checkbox"/> DIFF (manual) |
| <input type="checkbox"/> 25 OH Vitamin D | <input type="checkbox"/> Electrolytes |
| <input type="checkbox"/> 6MP | <input type="checkbox"/> Environmental Panel - Adult |
| <input type="checkbox"/> ACTH | <input type="checkbox"/> Environmental Panel - Pediatric |
| <input type="checkbox"/> Androstenedione | <input type="checkbox"/> Estradiol |
| <input type="checkbox"/> Antithyroid Ab Panel | <input type="checkbox"/> FSH |
| <input type="checkbox"/> CBC | <input type="checkbox"/> Hepatitis C Ab |
| <input type="checkbox"/> Celiac Panel | <input type="checkbox"/> Hepatitis C RNA PCR |
| <input type="checkbox"/> Chemistry Profile | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Chromosome Congenital | <input type="checkbox"/> Ionized Calcium |
| <input type="checkbox"/> Chromosome Fish | <input type="checkbox"/> IGF - 1 |
| <input type="checkbox"/> Chromosome Fragile X | <input type="checkbox"/> IGF - Binding Protein 3 |
| <input type="checkbox"/> Chromosome Subtelomeric Probe | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> C-Peptide Blood | <input type="checkbox"/> Ionized Calcium |
| <input type="checkbox"/> C Reactive protein | <input type="checkbox"/> LH |

- | |
|--|
| <input type="checkbox"/> Liver Panel |
| <input type="checkbox"/> Neonatal Screen |
| <input type="checkbox"/> Pre-Albumin |
| <input type="checkbox"/> Prolactin |
| <input type="checkbox"/> Rast |
| <input type="checkbox"/> Renin |
| <input type="checkbox"/> T3, FREE |
| <input type="checkbox"/> T4 |
| <input type="checkbox"/> TBII |
| <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Testosterone, FREE |
| <input type="checkbox"/> Thyroid Stimulating Immunoglobulins |
| <input type="checkbox"/> TPMT Genetics |
| <input type="checkbox"/> TSH |
| <input type="checkbox"/> VDRL (RPR) |

URINE

- | |
|--|
| <input type="checkbox"/> Calcium Urine |
| <input type="checkbox"/> Creatinine Urine |
| <input type="checkbox"/> Microalbumin-random |
| <input type="checkbox"/> Microalbumin-random 24 hour |
| <input type="checkbox"/> Urinalysis Macro |
| <input type="checkbox"/> Urinalysis Macro/reflex CX |
| <input type="checkbox"/> Urinalysis Micro |

<p>Check one:</p> <input type="checkbox"/> STAT <input type="checkbox"/> Routine <input type="checkbox"/> Surgery Pre-Op Date of Surgery: _____ Frequency if Standing order <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> _____ times / year
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ADDITIONAL TESTS / SURGICAL SPECIMENS Please include patient history and instructions below:

<p>LAB USE ONLY: Have you read back the information? Initials: _____</p>
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CALL BACK REQUESTS: Provider Telephone Number (Including area code): _____

Medical Necessity Regulations – At the government's request, the Clinical Laboratories would like to remind all providers that when ordering tests that will be paid under federal health programs, including Medicare and Medicaid, will pay only for those tests the relevant program deems to be (1) included as a covered service, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.

