NEWTON-WELLESLEY HOSPITAL

Follow these guidelines to ensure efficient and quality service when ordering Lab work for your Patients

Yellow Highlighted fields *REQUIRED* for authenticated order.

1. **Patient Name**
2. **Gender**
3. **Date of Birth**
4. **ICD-9 Diagnosis**
5. **Order Date**
6. **Signature**

Client Information
Your facility's address, phone numbers and location code will be pre-printed here. **If you have more than one Physician at your site, you must check the mnemonic of the Physician who is ordering the lab work.**

Room #
For long term care facilities.

Insurance Information
Please be sure that the billing information is complete upon submitting test specimen to prevent disruptive phone calls and improper billing to you or your patients.

Order & Collection Date
This information is required for billing.

Test Menu
Tests are categorized by department and tests in red indicate the Medicare Limited Coverage Tests.
If you request tests from different departments, you will need a separate sample for each additional test.

Immunology must have their own samples.

NEWTON-WELLESLEY HOSPITAL

Newton-Wellesley Hospital Laboratory

2014 Washington Street, Newton, MA 02462 CLIA# 22D0710787 CAP# 11517-01

PARTNERS HEALTHCARE

Patient Last Name ❶ First MI

Gender M❷F | Date of Birth / ❸ / | Room #

Medical Record Number | Social Security Number - -

Patient Home Address, City, State, Zip Code

Home Telephone | Other Telephone

Patient Insurance Company Name / Coverage (attach copy of card)

Certificate # / Policy # / Group #

Insurance Company Address, City, State, Zip

Subscriber Last Name First MI | Subscriber's Relationship to Patient | Subscriber Address

For lab-generated specimen labels upon receipt at lab.

❒ CLIENT BILL/FACILITY BILL/PPS to:

Send Copies to: _____

Please provide diagnostic information in the form of a valid ICD-9CM code or complete narrative diagnosis which has been documented in the patient's medical record

❹ _____ _____ _____ _____

Order Date / Time

/❺/ ____ AM / PM ❒ STAT! Use STAT Bag ❒ Call ( ) - ❒ Fax ( ) -

MD Signature: ❻ _____

Comments to appear on the report:

SPECIMEN INFORMATION

Collection Date / Time

/ / ____ AM / PM ❒ FASTING

Phlebotomist's Signature _____

PROFILES and PANELS

- ❒ **Electrolyte Panel (LYTES)** NA, K, CL, CO2
- ❒ **Basic Metabolic Panel (BMP)*** NA, K, CL, CO2, GLU*, CRE, CA, BUN
- ❒ **Comprehensive Metabolic Panel (CMP)*** NA, K, CL, CO2, GLU*, BUN, CRE, CA, TP, ALB, ALKPH, TBIL, ALT, AST
- ❒ **Hepatitis (Acute) Panel (HAP)*** HAVM, HBCM, HBSAG, HCR#
- ❒ **Liver / Hepatic Function Panel (LFT)** TP, ALB, ALKPH, TBIL, DBIL, ALT, AST
- ❒ **Lipid Panel Fasting (LIPIP)*** CHOL, TRIG, HDL, CALC
- ❒ **Lipid Panel Fasting with Reflex DLDL (LIPIPR)***
- ❒ **Obstetric Panel (/OBP)*** CBCD, HBSAG, RUB, PREN, RPR
- ❒ **Renal Function Panel (RFP)*** NA, K, CL, CO2, GLU*, BUN, CRE, CA, PHOS, ALB

MICROBIOLOGY

Source (required): _____

- ❒ AFB Culture & Smear (AFCS)
- ❒ Anaerobic Culture (ANER)
- ❒ Blood Culture (BLC) #
- ❒ Bronchial Culture (BRONC) #
- ❒ Cdiff A & B (CTOX)
- ❒ Cryptosporidium (CSPOR)
- ❒ Ear Culture (EARC) #
- ❒ Eye Culture (EYEC) #
- ❒ Fluid Culture (FLDC) #
- ❒ Fungal Culture (FUNG)
- ❒ Genital Culture (GENC) #
- ❒ Giardia Antigen (GAG)
- ❒ Herpes Culture w/ Reflex Typing (HERPR) #
- ❒ Stool Culture, Comprehensive (STLC) # (includes + Tests Below)
  - ❒ +Salmonella/Shigella # ❒ +Campylobacter ❒ +E Coli 0157 # ❒ +Yersinia #
- ❒ Chlamydia DNA (CTDNA)
- ❒ Rapid Strep (RSS)
- ❒ HPV PROBE (HPV)
- ❒ Influenza A & B (INFLU A B)
- ❒ KOH Prep (KOH)
- ❒ MRSA Screen (MRSA) #
- ❒ Nasal Culture (NASC) #
- ❒ Ova & Parasite (OAP)
- ❒ Pinworm Prep (PIN)
- ❒ Rectal Screen for Strep A (RECTALA)
- ❒ Rotavirus Antigen (RV)
- ❒ RSV Rapid by EIA (RSVR) #
- ❒ Skin Culture (SKIN)
- ❒ Sputum Culture (SPTC) #
- ❒ GC DNA (NGDNA)
- ❒ w/Reflex THSC (RSSC) #
- ❒ Strep A Throat Screen (THSC)
- ❒ Strep B Vag/Rectal Scr (GENB)
- ❒ Throat Culture (TC)
- ❒ Tissue Culture (TISC) #
- ❒ **Urine Culture (UC)***
- ❒ VRE Screen (VRE) #
- ❒ Wet Prep (WP)
- ❒ Wound Culture (WDC) #
- ❒ Other: _____
- ❒ Chlam/GC DNA (CTNGDNA)
- ❒ w/Reflex TC (RSSCR) #

CHEMISTRY

- ❒ Albumin (ALB)
- ❒ Alpha-Feto Prot (AFP)*
- ❒ ALT / SGPT
- ❒ AST / SGOT
- ❒ Alkaline Phos (ALKPH)
- ❒ Amylase (AMY)
- ❒ Bilirubin, Direct (DBIL)
- ❒ Bilirubin, Total (TBIL)
- ❒ CRP inflam (CRPROT)
- ❒ CRP high sens (CRPROTHS)
- ❒ CA 125*
- ❒ CA 15-3*
- ❒ CA 19-9*
- ❒ Calcium (CA)
- ❒ CEA*
- ❒ Chloride (CL)
- ❒ Cholesterol, Total (CHOL)*
- ❒ Carbon Dioxide (CO2)
- ❒ Creatinine (CRE)
- ❒ Creatine Kinase (CK)
- ❒ Digoxin (DIG)*
- ❒ Dilantin (DIL)
- ❒ Estradiol (ESTRA)
- ❒ Ferritin (FERR)*
- ❒ Folate (FOL)
- ❒ Free T4 (FT4)*
- ❒ FSH
- ❒ G-Glutamyl Trans (GGTP)*
- ❒ Glucose, Fasting (GLUF)*
- ❒ Glucose, Plasma (GLUP)*
- ❒ Glucose, Serum (GLU)*
- ❒ Hemoglobin A1C (A1C)*
- ❒ HCG Qualitative (HCGQL)
- ❒ HCG Quantitative (HCGQN)*
- ❒ HCG, Urine Qual (UHCG)
- ❒ HDL Cholesterol (HDL)*
- ❒ IGE
- ❒ Iron (FE)*
- ❒ Iron Saturation (FEIBC)*
- ❒ Lactate Dehydrogenase (LD)
- ❒ Lead Screen (LEADS)
- ❒ Lipase (LIPA)
- ❒ Luteinizing Hormone (LH)
- ❒ Magnesium (MG)*
- ❒ Microalbumin (UMA)
- ❒ Microalb/Creatinine (UMACRE)
- ❒ Phosphorous (PHOS)
- ❒ Potassium (K)
- ❒ Progesterone (PROG)
- ❒ Prolactin (PROL)
- ❒ Protein Electro, Serum (SPEP)
- ❒ Protein Electro, Urine (UPEP)
- ❒ PSA Diagnostic (PSAD)*
- ❒ PSA Screening (PSAS)*
- ❒ PSA Tot/Free Diagnostic (PSAFT)*
- ❒ Quad / AFP Screen (QUAD)*
- ❒ T3-Uptake (TU)*
- ❒ T4, Total (TT4)*
- ❒ Testosterone, Total (TEST)
- ❒ Testosterone, Tot/Free (TESTF)
- ❒ Total Protein (TP)
- ❒ Total T3 (TT3)
- ❒ Triglyceride (TRIG)*
- ❒ TSH*
- ❒ Tumor Marker (HCGTM)
- ❒ Urea Nitrogen (BUN)
- ❒ Uric Acid (URIC)
- ❒ Valproic Acid (VAL)
- ❒ Vitamin B12 (B12)
- ❒ Venipuncture Charge (V)

OTHER TESTS

_____

_____

_____

_____

COAGULATION

- ❒ APTT (PTT)*
- ❒ PT with INR (PT)*

HEMATOLOGY

- ❒ CBC*
- ❒ CBC with Diff (CBCD)*
- ❒ CBC with Reflex Diff (CBCR)* #
- ❒ Hematocrit (HCT)*
- ❒ Reticulocyte Count (RET)*
- ❒ Sedimentation Rate (ESR)
- ❒ WBC*

IMMUNOLOGY

- ❒ ANA with Reflex Titer (ANAR) #
- ❒ Helicobacter Pylori Ab (HPY)
- ❒ Hepatitis A IGM (HAVM)
- ❒ Hepatitis B Core IGM (HBCM)
- ❒ Hepatitis B Surf AB (HBSAB)
- ❒ Hepatitis B Surf AG (HBSAG)
- ❒ Hepatitis C Ab with Reflex (HCR) #
- ❒ Lyme Ab with Reflex (LYME) #
- ❒ Mono / Hetero AB (MONOT)
- ❒ Rheumatoid Factor (RF)
- ❒ RPR with Reflex (RPR) #
- ❒ Rubella Immunity (RUB)

URINALYSIS

- ❒ Occult Bld, Feces (SOCCS)* Colorectal Screening
- ❒ Occult Bld, Feces (SOCCD)* Symptomatic
- ❒ Urinalysis, with Microscopy (UA)
- ❒ UA without Sediment (UAS)
- ❒ UA with Reflex Culture (UAR) #

BLOOD BANK

- ❒ **Prenatal Screen (PREN)** # (includes + tests below)
  - ❒ +Type and Rh (ABRH)
  - ❒ +Antibody Screen w/reflex ID (ABS) #
  - ❒ Antibody Titer (ABT)
- ❒ Type only (ABO) ❒ Rh only
- ❒ Rhlg Evaluation (RHEV)
- ❒ Direct Antiglobulin Test (DAT)

056719 (4/09)

 # Denotes Reflex Testing -- See Reverse Side of Requisition ***RED Denotes Medicare / ABN Eligible Testing**

NEWTON-WELLESLEY HOSPITAL

Follow these guidelines to ensure efficient and quality service when ordering Lab work for your Patients

Yellow Highlighted fields *REQUIRED* for authenticated order.

1. **Patient Name**
2. **Gender**
3. **Date of Birth**
4. **ICD-9 Diagnosis**
5. **Order Date**
6. **Signature**

Client Information
Your facility's address, phone numbers and location code will be pre-printed here. **If you have more than one Physician at your site, you must check the mnemonic of the Physician who is ordering the lab work.**

Room #
For long term care facilities.

Insurance Information
Please be sure that the billing information is complete upon submitting test specimen to prevent disruptive phone calls and improper billing to you or your patients.

Order & Collection Date
This information is required for billing.

Cytology/Pathology
Make sure to write in LMP and mark the source correctly. If this is not filled in properly, the wrong diagnosis could be made.

Test Menu
All tests are Medicare Limited Coverage Tests. **If you request tests from a different department, you will need to also submit a general lab requisition. A separate sample for each additional test is also required.**

NEWTON-WELLESLEY HOSPITAL

Newton-Wellesley Hospital Laboratory

2014 Washington Street, Newton, MA 02462 CLIA# 22D0710787 CAP# 11517-01

PARTNERS HEALTHCARE

Patient Last Name ❶	First	MI
Gender ❷ M F	Date of Birth ❸ / /	Room #
Medical Record Number	Social Security Number - -	
Patient Home Address, City, State, Zip Code		
Home Telephone	Other Telephone	
Patient Insurance Company Name / Coverage (attach copy of card)		
Certificate # / Policy # / Group #		
Insurance Company Address, City, State, Zip		

For lab-generated specimen labels upon receipt at lab.

Subscriber Last Name	First	MI	Subscriber's Relationship to Patient
Subscriber Address			
❒ CLIENT BILL/FACILITY BILL/PPS to:			
Send Copies to:			

Please provide diagnostic information in the form of a valid ICD-9CM code or complete narrative diagnosis which has been documented in the patient's medical record ❹

Order Date / Time ❺ / / ____ AM / PM ❒ STAT! Use STAT Bag ❒ Call ( ) - ❒ Fax ( ) -

MD Signature: ❻

SPECIMEN INFORMATION

Collection Date / Time / / ____ AM / PM

Comments to appear on the report:

GYN CYTOLOGY

☐ ThinPrep Pap (recommended for age 20 and younger)
☐ ThinPrep Pap with REFLEX high-risk HPV upon interpretation of atypical cells
☐ ThinPrep Pap with high-risk HPV (option for age 30 and older)
☐ Conventional Pap

Source: ☐ Cervical ☐ Vaginal

Menstrual Status

LMP:_____

☐ Postmenopausal ☐ Pregnant
☐ Total Hysterectomy ☐ Postpartum
☐ Subtotal Hysterectomy (cervix not removed)

Clinical History

☐ Normal / routine exam
☐ Previous abnormal cytology/biopsy
☐ High Risk (V15.89)
☐ HPV infection
☐ Depo Provera
☐ Radiation / Chemotherapy
☐ Birth Control Pills (BCP)
☐ Hormone therapy (not BCP)
☐ IUD
☐ Abnormal bleeding
☐ Other abnormal history:_____

NON-GYNECOLOGIC CYTOLOGY

☐ Random / Voided Urine
☐ Catheterized / Cysto Urine
☐ Other:_____

☐ Fine Needle Aspiration, Thyroid
☐ Fine Needle Aspiration, Breast
☐ Fine Needle Aspiration, Other

Side: _____
Side: _____
Location: _____

Clinical Impression:_____

SURGICAL PATHOLOGY

Tissue submitted: _____
Procedure:_____
Clinical Impression / Reason for Procedure: _____

057389 (4/09)