Account Information

WakeMed

Pathology Laboratory
Phone: (919) 350-8242

Clinical Laboratory Requisition

Patient Information

Name: Last ______ First ______ MI ______

Address: Street or PO Box ______ REQUIRED

City ______ State ______ Zip ______

Phone number ______ Marital Status: S M Sep D W ______ Soc. Sec. No. ______

Sex: M F | Date of Birth | Collection Date / Time / Initials | ☐ **STAT**

Medical Record #:

Physician Information

Referring Physician: ______ REQUIRED (______)
Last Name First Name
(If PA or NP, indicate supervising physician in parentheses)

Physician's Signature: ______ REQUIRED

CALL Report To: ______

☐ During Normal Business Hours (9-5)
☐ Outside Business Hours (requires Ordering MD approval)

FAX Report To: ______

Diagnosis

Diagnosis/Signs/Symptoms in ICD-10 Format (Highest Specificity)

REQUIRED

(Diagnosis must support medical necessity requirements.)

Billing Information *(Check one)*
Only required when sending samples

☐ Bill to Medicare No: ______
☐ Bill Doctor account
☐ Bill Patient Insurance
☐ Bill to patient (Address given)

Insurance/Medicare/Medicaid Information: ______

Claims mailing address: ______ City ______ State ______ Zip ______

Policy No: ______ Group No: ______ If group, name of employer: ______

Insured or responsible party, if other than patient: ______ Insured Soc. Sec. No.: ______

Insured Date of Birth: ______ Patient relationship to insured: ☐ Spouse ☐ Child ☐ Other

Please attach a copy of patient's primary & secondary insurance information if available.

Frequently Ordered Panels

Test	Tube	Code
☐ Basic Metabolic	ORNG	80048
☐ Comprehensive Metabolic	ORNG	80053
☐ Hepatic Function	ORNG	80076
☐ Acute Hepatitis	ORNG	80074
☐ Lipid	ORNG	80061
☐ Electrolyte	ORNG	80051

Reproductive Testing

Test	Tube	Code
☐ Estradiol	ORNG	82670
☐ Fetal Fibronectin	SpecKit	82731
☐ Fetal Lung Maturity	AmnioFl	83663
☐ HCG, Quantitative	ORNG	84702
☐ FSH	ORNG	83001
☐ LH	ORNG	83002
☐ Progesterone	ORNG	84144
☐ Prolactin	ORNG	84146
☐ Testosterone	ORNG	84403
☐ Semen Analysis (Raleigh Campus Only)	Semen	89320
☐ Sperm Count (Post Vasectomy)	Semen	89310

Microbiology/Special/Other Testing

Test	Source	Code
☐ ßStrep Throat, Rapid	Throat	87802
☐ Urine Culture	Gray Urine Tube	87086
☐ Abscess Culture	Source	87075
☐ AFB Culture & Smear	Source	87116
☐ Blood Culture x ______	BLCultBtl	87040
☐ Fungus Culture	Source	87102
☐ Wound Culture	Source	87075
☐ Gram Stain	Source	87205
☐ ßStrep Throat, Culture	Throat	87081
☐ ßStrep Culture, Genital	Genital	87080
☐ C. Difficile Toxin	Stool	87324
☐ Chlamydia/GC DNA Probe	Swab/Urine	87591/87491
☐ Ova & Parasites	KIT	87177
☐ H. Pylori Ab	SST	86677
☐ Mononucleosis	ORNG	86308
☐ Rotavirus	Stool	87425

Chemistry Tests

Test	Tube	Code
☐ Albumin	ORNG	82040
☐ Alkaline Phosphatase	ORNG	84075
☐ ALT	ORNG	84460
☐ Amylase	ORNG	82150
☐ ANA	SST	86038
☐ AST	ORNG	84450
☐ Bilirubin, Direct	ORNG	82248
☐ Biliribin, Total	ORNG	82247
☐ B-Type Natriuretic Peptide	PEARL	83880
☐ BUN	ORNG	84520
☐ Calcium, Ionized	ORNG	82330
☐ Calcium, Total	ORNG	82310
☐ Cholesterol, Total	ORNG	82465
☐ CK	ORNG	82550
☐ Cortisol ___AM___PM	ORNG	82533
☐ Creatinine	ORNG	82565
☐ CRP	ORNG	86140
☐ Ferritin	ORNG	82728
☐ Folate	ORNG	82746
☐ GGT	ORNG	82977
☐ Glucose, Fasting	ORNG	82947
☐ Glucose, Random	ORNG	82947
☐ Gly-Hgb A1C	LAV	83036
☐ Hepatitis A IgM	ORNG	87609
☐ Hepatitis B Surface Ag	ORNG	87340
☐ Hepatitis B Surface Ab	ORNG	86706
☐ Hepatitis-HCV	ORNG	86803
☐ HIV Ab	ORNG	86703
☐ Iron	ORNG	83540
☐ Iron w/TIBC	ORNG	83550
☐ Lipase	ORNG	83690
☐ LDH	ORNG	83615
☐ Magnesium	ORNG	83735
☐ Phosphorous	ORNG	84100
☐ Potassium	ORNG	84132
☐ Prealbumin	ORNG	84134
☐ PSA	ORNG	84154
☐ PTH	ORNG	83519
☐ Rheumatoid Arthritis	ORNG	86431
☐ Sodium	ORNG	84295
☐ Total Protein	ORNG	84155
☐ Triglycerides	ORNG	84478
☐ TSH	ORNG	84443
☐ T4, Free	ORNG	84439
☐ Uric Acid	ORNG	84550
☐ Urinalysis	Urine	81003
☐ Urinalysis, Microscopic	Urine	81001
☐ Urine Protein Electrophoresis	Urine	84156/84166
☐ Vitamin B12	ORNG	82607
☐ Vitamin D-25 Hydroxy	SST	82306

Hematology/Transfusion

Test	Tube	Code
☐ CBC (No Diff)	LAV	85027
☐ CBC w/Diff	LAV	85025
☐ Hematocrit	LAV	85014
☐ Hemoglobin	LAV	85018
☐ Platelet Count	LAV	85049
☐ PT/INR	BLUE	85610
☐ PTT	BLUE	85730
☐ Retic Count	LAV	85045
☐ Sed Rate	BLACK	85651
☐ ABO Group & Rh Type	PINK	86900/86901
☐ Type & Screen	PINK	86900/86901/86850
☐ Platelet Antibody Panel	SST	86022x4
☐ Platelet Function Study	BLUE	85576
☐ TCT	BLUE	85670

Therapeutic Drug Level

Date/Time of Last Dose: ______

Test	Tube	Code
☐ Carbamazepine (Tegretol®)	ORNG	80156
☐ Digoxin (Lanoxin®)	ORNG	80162
☐ Lithium (Eskalith®)	ORNG	80178
☐ Phenobarbital (Luminal®)	ORNG	80184
☐ Phenytoin (Dilantin®)	GrNoGel	80186
☐ Theophylline	ORNG	80198
☐ Tobramycin	ORNG	80200
☐ Vancomycin	ORNG	80202
☐ Valproic Acid (Depakote®)	ORNG	80164

24 Hour Urine

Test	Tube	Code
☐ Creatinine	Urine	82570
☐ Creatinine Clearance	Urine + ORNG	82575
☐ Total Protein	Urine	84156

Other ______

Date Collected ______

EKG

☐ EKG (ECG) 93000

Scheduled Tests

Please see reverse for locations and information

☐ Glucose Tolerance Test OB Screen
☐ Glucose Tolerance 3 Hour Diagnostic
☐ Diabetes Diagnostic
☐ Therapeutic Blood Donation
Cary & North Campuses Only

☐ Body Fluid Source: ______
Test: ______

☐ Other: ______

Additional Notes: ______

For additional forms call (919) 350-8340, ask for Form # SP-017 REV. 9/15 jg

LOCATIONS

WakeMed Raleigh Medical Park
23 Sunnybrook Road
Raleigh, NC 27610

Phone: 919-350-8238
Fax: 919-350-7383

Hours: 7:00am - 5:00pm M-F

WakeMed Cary Hospital
1900 Kildaire Farm Road
Cary, NC 27518

Phone: 919-350-2370
Fax: 919-350-2375

Hours: 6:00am - 6:00pm M-F
9:00am - 1:00pm Saturday

WakeMed Garner Healthplex
400 U.S. Highway 70 East
Garner, NC 27529

Phone: 919-350-9680
Fax: 919-661-8413

Hours: 7:30am - 5:30pm M-F

WakeMed Apex Healthplex
120 Healthplex Way
Apex, NC 27502

Phone: 919-350-4325
Fax: 919-363-3315

Hours: 7:30am - 4:30pm M-F

WakeMed North Family Health & Women's Hospital
10000 Falls of Neuse Road
Raleigh, NC 27614

Phone: 919-350-1526
Fax: 919-350-1355

Hours: 8:00am - 4:30pm M-F

WakeMed Brier Creek Healthplex
8001 TW Alexander Drive
Raleigh, NC 27617

Phone: 919-350-9623
Fax: 919-598-0665

Hours: 7:30am - 4:30pm M-F

Advance Beneficiary Notice (ABN)

This section for office use only:
Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

I believe that in your case, Medicare is likely to deny payment for the following {specify test(s)}: ____

____

____ for the following reason(s):

Please check one that applies:
____ Medicare does not pay for tests for screening purposes or routine exams
____ Medicare does not pay for tests which are for "investigative or research use only"
____ Medicare does not pay for services for the diagnosis code provided
____ Medicare allows payment for this procedure only a limited number of times within a specific time period. WakeMed is not aware of other billings for this procedure by other health care providers.

Beneficiary Agreement: I have been notified by my physician / provider that he/ she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated.

CHECK ONE: ____ If Medicare denies payment, I agree to be fully and personally responsible for payment to WakeMed.
____ I decline to have the test(s).

____________________	____________________	____________________
Date of Service	*Patient or Guarantor Signature*	*Witness*