Heartland Health Laboratories, Inc.
10435 Lackman Rd Lenexa, Kansas 66219
913-643-4278 Fax 913-643-4282 CLIA ID. 17D1027382

Highlighted Information Areas Required

Name ______________________ **Test Date**____/____/____
(Last name, First name) **OR**
Next Lab Day __________

Facility ______________________ **Room #** ____________

SSN _______-_____-_________ **D.O.B.** ____/____/____ **Sex M F**

Ordering Physician________________________________
(Last name, First name)

Routine _________ **STAT** _________ **If STAT Phone LAB IMMEDIATELY**

Ordering Initials:_______________

Billing Information

***Bill to: Insurance ______ Facility ______ (Part A, Man.Care,VA)**

Primary Ins ____

ID # ____

Is patient enrolled in Hospice? Yes ____ No ____

If yes, Hospice name: ________________________________

Hospice DX: ____________________ Start date: ____/____/____

***DIAGNOSIS:**

1) ____________________ 2) ____________________

3) ____________________ 4) ____________________

***A VALID DIAGNOSIS IS REQUIRED FOR EACH TEST.**

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 payment standards, Medicare will deny payment for that service. "If Medicare denies payment, I agree to be personally and fully responsible for payment."

________________________________ ____________
Responsible party's signature Date

PROFILES — DX CODE

_____ **BASIC METABOLIC PANEL** ________
BUN, CALCIUM, CO2, CHLORIDE, CREATININE, GLUCOSE, POTASSIUM, SODIUM

_____ **COMPREHENSIVE METABOLIC PANEL** ________
ALBUMIN, ALK PHOS, ALT/SGPT, AST/SGOT, BUN, CALCIUM, CHLORIDE, CO2, CREATININE, GLUCOSE, POTASSIUM, SODIUM, TOTAL BILIRUBIN, TOTAL PROTEIN

_____ **ELECTROLYTE PANEL** ________
CHLORIDE, CO2, POTASSIUM, SODIUM

_____ **RENAL PANEL** ________
ALBUMIN, BUN, CALCIUM, CO2, CHLORIDE, CREATININE, GLUCOSE, PHOSPHORUS, POTASSIUM, SODIUM

_____ **HEPATIC FUNCTION PANEL(Liver Profile)**________
ALBUMIN, ALK PHOS, DIRECT BILIRUBIN, AST/SGOT, ALT/SGPT, TOTAL BILIRUBIN, TOTAL PROTEIN

_____ **HEPATITIS PANEL** ________
HEP A ANTIBODY, HEP B CORE ANTIBODY, HEP B SURFACE ANTIGEN, HEP C ANTIBODY

_____ **LIPID PROFILE** ________
CHOLESTEROL, HDL, TRIGLYCERIDES

HHL USE ONLY

PHLEBOTOMIST INITIALS: ______________DATE: ___/___/____

SPECIMEN: SST___ BLUE____ LAV____ GREEN____ RED____

URINE____ STOOL____ OB____ SWAB____ TIME: ____________

REQUISITION PICKED UP: ___________________

SPECIMEN REQUIREMENTS
ALL CHEMISTRY PROFILES REQUIRE SPECIMEN TO BE DRAWN IN SST(SERUM SEPARATION TUBE). AMMONIA DRAWN IN GREEN TOP ON ICE. CENTRIFUGE IMMEDIATELY.
GLYCOSYLATED HgB(A1C) and PTH, THESE REQUIRE A LAVENDER TOP.
HEMATOLOGY SPECIMENS WITH THE EXCEPTION OF PT & PTT REQUIRE A LAVENDER TOP.
PROTIMES AND PTT REQUIRE A BLUE TOP.

TESTS — DX CODE

___ ALBUMIN ______
___ ALK PHOS ______
___ AMMONIA (Green) ______
___ AMYLASE ______
___ BNP ______
___ BUN ______
___ B12 ______
___ CALCIUM ______
___ CHOLESTEROL ______
___ CPK (CK) ______
___ CRP ______
___ CREATININE ______
___ DIGOXIN ______
___ DILANTIN ______
___ FERRITIN ______
___ FOLATE ______
___ GLUCOSE ______
___ HGB-A1C (GLYCO)(Lav) ______
___ IRON/TIBC ______
___ KEPPRA (Red) ______
___ LDH ______
___ LIPASE ______
___ LITHIUM ______
___ MAGNESIUM ______
___ PHENOBARBITOL ______
___ PHOSPHORUS ______
___ POTASSIUM (K) ______
___ PREALBUMIN ______
___ PSA ______
___ PTH (Lav) ______
___ SGOT (AST) ______
___ SGPT (ALT) ______
___ SODIUM ______
___ TEGRETOL ______
___ THEOPHYLLINE ______
___ T4 (THYROXINE) ______
___ T4, FREE ______
___ T3, TOTAL ______
___ TROPONIN ______
___ TSH ______
___ TOTAL PROTEIN ______
___ TRIGLYCERIDES ______
___ URIC ACID ______
___ VALPROIC ACID ______
___ VIT D 25 OH ______

HEMATOLOGY — DX CODE

___ CBC WITH DIFF ______
___ CBC – NO DIFF ______
___ HGB/HCT ______
___ PLATELET COUNT ______
___ PT W/ INR (Blue) ______
___ APTT (Blue) ______
___ D-DIMER (Blue) ______
___ SED RATE (ESR) ______
___ RETIC COUNT ______

URINE STUDIES — DX CODE

___ UA * (reflex) ________
w/ C&S if indicated

___ URINALYSIS * ________
w/ CULTURE & SENSITIVITY

*CLEAN CATCH ____ FOLEY ____
STRAIGHT CATH ____

MICROBIOLOGY — DX CODE

___ BLOOD CULTURE ______
___ C-DIFF, STOOL ______
___ CULTURE, **OTHER**** ______
___ INFLUENZA, RAPID ______
___ OCCULT BLOOD ______
___ OVA & PARASITES ______
___ SPUTUM w/GRAM STAIN______
___ STOOL CULTURE ______
___ THROAT CULTURE ______
___ URINE CULTURE* ______
*CLEAN CATCH _____FOLEY_____
STRAIGHT CATH _____
___ WOUND, w/GRAM STAIN ______
****(INDICATE SITE)**

**** SPECIFY SITE/SOURCE**

OTHER TESTS NOT LISTED:

__________________ ______
__________________ ______
__________________ ______