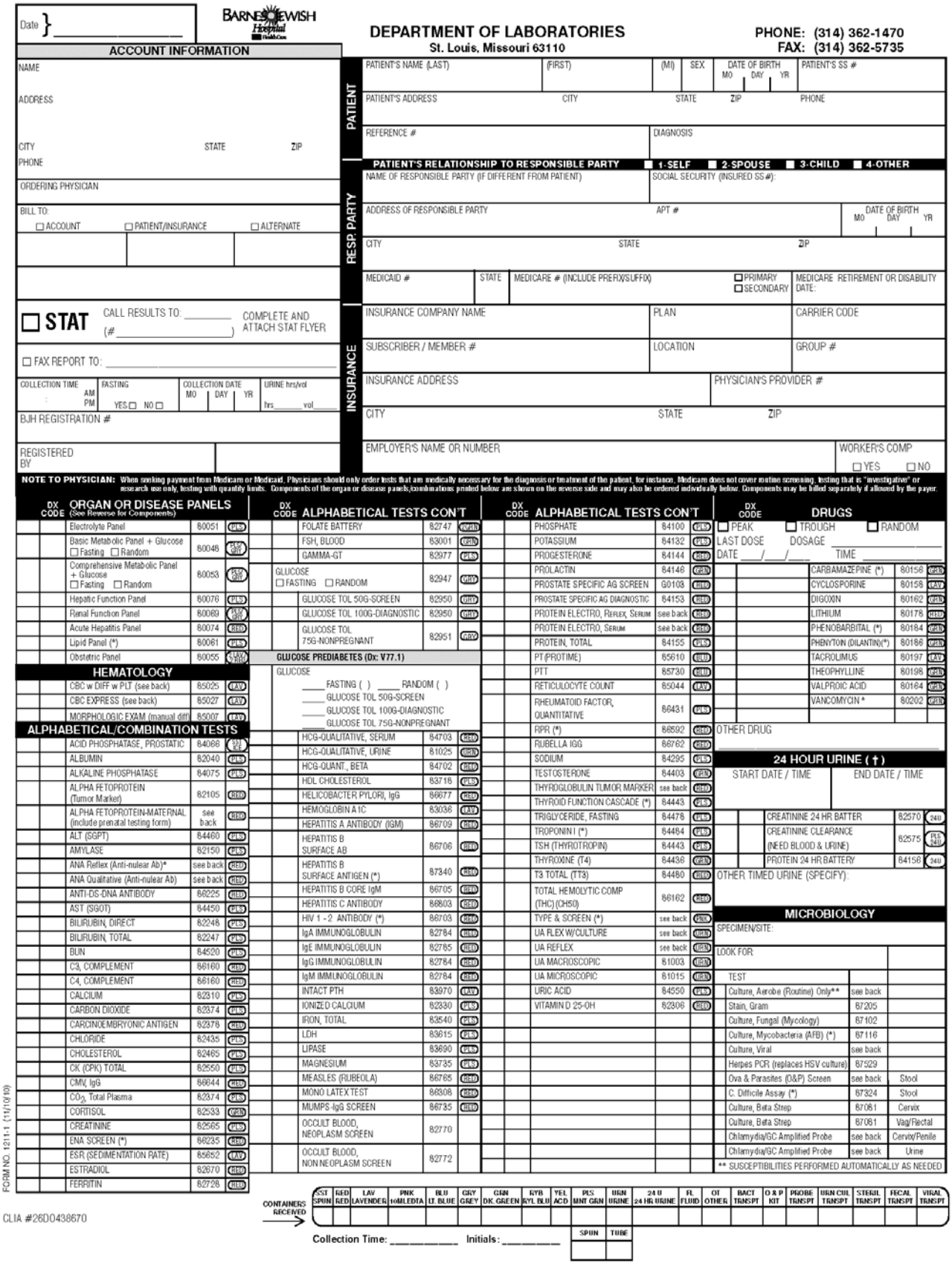
Request Forms

Barnes-Jewish Hospital Department of Laboratories (Front)



Date } _____

BARNES-JEWISH Hospital

DEPARTMENT OF LABORATORIES
St. Louis, Missouri 63110

PHONE: (314) 362-1470
FAX: (314) 362-5735

ACCOUNT INFORMATION

NAME
ADDRESS
CITY STATE ZIP
PHONE
ORDERING PHYSICIAN
BILL TO: ☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

☐ **STAT** CALL RESULTS TO: _____ (# _____) COMPLETE AND ATTACH STAT FLYER

☐ FAX REPORT TO: _____

COLLECTION TIME : AM PM | FASTING YES☐ NO☐ | COLLECTION DATE MO DAY YR | URINE hrs/vol hrs_____ vol_____

BJH REGISTRATION #

REGISTERED BY

PATIENT

PATIENT'S NAME (LAST) | (FIRST) | (MI) | SEX | DATE OF BIRTH MO DAY YR | PATIENT'S SS #

PATIENT'S ADDRESS | CITY | STATE | ZIP | PHONE

REFERENCE # | DIAGNOSIS

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ■ 1-SELF ■ 2-SPOUSE ■ 3-CHILD ■ 4-OTHER

RESP. PARTY

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) | SOCIAL SECURITY (INSURED SS #):

ADDRESS OF RESPONSIBLE PARTY | APT # | DATE OF BIRTH MO DAY YR

CITY | STATE | ZIP

MEDICAID # | STATE | MEDICARE # (INCLUDE PREFIX/SUFFIX) ☐ PRIMARY ☐ SECONDARY | MEDICARE RETIREMENT OR DISABILITY DATE:

INSURANCE

INSURANCE COMPANY NAME | PLAN | CARRIER CODE

SUBSCRIBER / MEMBER # | LOCATION | GROUP #

INSURANCE ADDRESS | PHYSICIAN'S PROVIDER #

CITY | STATE | ZIP

EMPLOYER'S NAME OR NUMBER | WORKER'S COMP ☐ YES ☐ NO

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits. Components of the organ or disease panels/combinations printed below are shown on the reverse side and may also be ordered individually below. Components may be billed separately if allowed by the payer.

ORGAN OR DISEASE PANELS (See Reverse for Components)

DX CODE			
	Electrolyte Panel	80051	(PLS)
	Basic Metabolic Panel + Glucose ☐ Fasting ☐ Random	80048	(PLS/GRN)
	Comprehensive Metabolic Panel + Glucose ☐ Fasting ☐ Random	80053	(PLS/GRN)
	Hepatic Function Panel	80076	(PLS)
	Renal Function Panel	80069	(PLS/GRN)
	Acute Hepatitis Panel	80074	(HEM)
	Lipid Panel (*)	80061	(PLS)
	Obstetric Panel	80055	(LAV/HEM)

HEMATOLOGY

	CBC w DIFF w PLT (see back)	85025	(LAV)
	CBC EXPRESS (see back)	85027	(LAV)
	MORPHOLOGIC EXAM (manual diff)	85007	(LAV)

ALPHABETICAL/COMBINATION TESTS

	ACID PHOSPHATASE, PROSTATIC	84066	(SPIN ICE)
	ALBUMIN	82040	(PLS)
	ALKALINE PHOSPHATASE	84075	(PLS)
	ALPHA FETOPROTEIN (Tumor Marker)	82105	(HEM)
	ALPHA FETOPROTEIN-MATERNAL (include prenatal testing form)	see back	(HEM)
	ALT (SGPT)	84460	(PLS)
	AMYLASE	82150	(PLS)
	ANA Reflex (Anti-nulear Ab)*	see back	(HEM)
	ANA Qualitative (Anti-nulear Ab)	see back	(HEM)
	ANTI-DS-DNA ANTIBODY	86225	(HEM)
	AST (SGOT)	84450	(PLS)
	BILIRUBIN, DIRECT	82248	(PLS)
	BILIRUBIN, TOTAL	82247	(PLS)
	BUN	84520	(PLS)
	C_3, COMPLEMENT	86160	(HEM)
	C_4, COMPLEMENT	86160	(HEM)
	CALCIUM	82310	(PLS)
	CARBON DIOXIDE	82374	(PLS)
	CARCINOEMBRYONIC ANTIGEN	82378	(HEM)
	CHLORIDE	82435	(PLS)
	CHOLESTEROL	82465	(PLS)
	CK (CPK) TOTAL	82550	(PLS)
	CMV, IgG	86644	(HEM)
	CO_2, Total Plasma	82374	(PLS)
	CORTISOL	82533	(GRN)
	CREATININE	82565	(PLS)
	ENA SCREEN (*)	86235	(HEM)
	ESR (SEDIMENTATION RATE)	85652	(LAV)
	ESTRADIOL	82670	(HEM)
	FERRITIN	82728	(HEM)

ALPHABETICAL TESTS CON'T

DX CODE			
	FOLATE BATTERY	82747	(GRN)
	FSH, BLOOD	83001	(GRN)
	GAMMA-GT	82977	(PLS)
	GLUCOSE ☐ FASTING ☐ RANDOM	82947	(GRY)
	GLUCOSE TOL 50G-SCREEN	82950	(GRY)
	GLUCOSE TOL 100G-DIAGNOSTIC	82950	(GRY)
	GLUCOSE TOL 75G-NONPREGNANT	82951	(GRY)

GLUCOSE PREDIABETES (Dx: V77.1)

GLUCOSE
_____ FASTING ( ) _____ RANDOM ( )
_____ GLUCOSE TOL 50G-SCREEN
_____ GLUCOSE TOL 100G-DIAGNOSTIC
_____ GLUCOSE TOL 75G-NONPREGNANT

	HCG-QUALITATIVE, SERUM	84703	(HEM)
	HCG-QUALITATIVE, URINE	81025	(URN)
	HCG-QUANT., BETA	84702	(HEM)
	HDL CHOLESTEROL	83718	(PLS)
	HELICOBACTER PYLORI, IgG	86677	(HEM)
	HEMOGLOBIN A1C	83036	(LAV)
	HEPATITIS A ANTIBODY (IGM)	86709	(HEM)
	HEPATITIS B SURFACE AB	86706	(HEM)
	HEPATITIS B SURFACE ANTIGEN (*)	87340	(HEM)
	HEPATITIS B CORE IgM	86705	(HEM)
	HEPATITIS C ANTIBODY	86803	(HEM)
	HIV 1 -2 ANTIBODY (*)	86703	(HEM)
	IgA IMMUNOGLOBULIN	82784	(HEM)
	IgE IMMUNOGLOBULIN	82785	(HEM)
	IgG IMMUNOGLOBULIN	82784	(HEM)
	IgM IMMUNOGLOBULIN	82784	(HEM)
	INTACT PTH	83970	(LAV)
	IONIZED CALCIUM	82330	(PLS)
	IRON, TOTAL	83540	(PLS)
	LDH	83615	(PLS)
	LIPASE	83690	(PLS)
	MAGNESIUM	83735	(PLS)
	MEASLES (RUBEOLA)	86765	(HEM)
	MONO LATEX TEST	86308	(HEM)
	MUMPS-IgG SCREEN	86735	(HEM)
	OCCULT BLOOD, NEOPLASM SCREEN	82270	
	OCCULT BLOOD, NON NEOPLASM SCREEN	82272	

ALPHABETICAL TESTS CON'T

DX CODE			
	PHOSPHATE	84100	(PLS)
	POTASSIUM	84132	(PLS)
	PROGESTERONE	84144	(HEM)
	PROLACTIN	84146	(GRN)
	PROSTATE SPECIFIC AG SCREEN	G0103	(HEM)
	PROSTATE SPECIFIC AG DIAGNOSTIC	84153	(HEM)
	PROTEIN ELECTRO, REFLEX, SERUM	see back	(HEM)
	PROTEIN ELECTRO, SERUM	see back	(HEM)
	PROTEIN, TOTAL	84155	(PLS)
	PT (PROTIME)	85610	(HEM)
	PTT	85730	(HEM)
	RETICULOCYTE COUNT	85044	(LAV)
	RHEUMATOID FACTOR, QUANTITATIVE	86431	(IMM)
	RPR (*)	86592	(HEM)
	RUBELLA IGG	86762	(HEM)
	SODIUM	84295	(PLS)
	TESTOSTERONE	84403	(GRN)
	THYROGLOBULIN TUMOR MARKER	see back	(HEM)
	THYROID FUNCTION CASCADE (*)	84443	(PLS)
	TRIGLYCERIDE, FASTING	84478	(PLS)
	TROPONIN I (*)	84484	(IMM)
	TSH (THYROTROPIN)	84443	(GRN)
	THYROXINE (T4)	84436	(GRN)
	T3 TOTAL (TT3)	84480	(GRN)
	TOTAL HEMOLYTIC COMP (THC) (CH50)	86162	(HEM)
	TYPE & SCREEN (*)	see back	(BNK)
	UA FLEX W/CULTURE	see back	(URN)
	UA REFLEX	see back	(URN)
	UA MACROSCOPIC	81003	(URN)
	UA MICROSCOPIC	81015	(URN)
	URIC ACID	84550	(PLS)
	VITAMIN D 25-OH	82306	(HEM)

DRUGS

☐ PEAK ☐ TROUGH ☐ RANDOM
LAST DOSE DATE ___/___/___ DOSAGE _____ TIME _____

	CARBAMAZEPINE (*)	80156	(GRN)
	CYCLOSPORINE	80158	(LAV)
	DIGOXIN	80162	(GRN)
	LITHIUM	80178	(HEM)
	PHENOBARBITAL (*)	80184	(GRN)
	PHENYTOIN (DILANTIN)(*)	80186	(GRN)
	TACROLIMUS	80197	(LAV)
	THEOPHYLLINE	80198	(GRN)
	VALPROIC ACID	80164	(GRN)
	VANCOMYCIN *	80202	(GRN)

OTHER DRUG _____

24 HOUR URINE (†)

START DATE / TIME | END DATE / TIME

	CREATININE 24 HR BATTER	82570	(24U)
	CREATININE CLEARANCE (NEED BLOOD & URINE)	82575	(PLS/24U)
	PROTEIN 24 HR BATTERY	84156	(24U)

OTHER TIMED URINE (SPECIFY): _____

MICROBIOLOGY

SPECIMEN/SITE: _____

LOOK FOR

TEST		
Culture, Aerobe (Routine) Only**	see back	
Stain, Gram	87205	
Culture, Fungal (Mycology)	87102	
Culture, Mycobacteria (AFB) (*)	87116	
Culture, Viral	see back	
Herpes PCR (replaces HSV culture)	87529	
Ova & Parasites (O&P) Screen	see back	Stool
C. Difficile Assay (*)	87324	Stool
Culture, Beta Strep	87081	Cervix
Culture, Beta Strep	87081	Vag/Rectal
Chlamydia/GC Amplified Probe	see back	Cervix/Penile
Chlamydia/GC Amplified Probe	see back	Urine

** SUSCEPTIBILITIES PERFORMED AUTOMATICALLY AS NEEDED

FORM NO. 1211-1 (11/10)10)

CLIA #26D0438670

CONTAINERS RECEIVED →

SST SPUN	RED RED	LAV LAVENDER	PNK 10MLEDTA	BLU LT. BLUE	GRY GREY	GRN DK. GREEN	RYB KYL BLU	YEL ACD	PLS MNT GRN	URN URINE	24 U 24 HR URINE	FL FLUID	OT OTHER	BACT TRNSPT	O & P KIT	PSOBE TRNSPT	URN CUL TRNSPT	STERIL TRNSPT	FECAL TRNSPT	VIRAL TRNSPT

Collection Time: _____ Initials: _____

SPUN	TUBE

Barnes-Jewish Hospital Department of Laboratories (Back)

TEST COMBINATION / PANEL POLICY

Barnes Jewish Hospital Department of Lab policy is to provide physicians, in each instance, with the flexibility to choose appropriate tests to assure that the convenience of ordering test combinations/panels does not distance physicians who wish to order a test combination/panel from making deliberate decisions regarding which tests are truly medically necessary. All the tests offered in test combinations/panels may be ordered individually using the request form.

In an effort to keep our clients fully informed of the content, charges and coding of its test combinations/panels when billed to Medicare, we periodically send notices concerning test combinations/panels, as well as information regarding patient fees for all services. We also welcome the opportunity to provide, on request, additional information in connection with our testing services and the manner in which they are billed to physicians, health care plans, and patients.

The CPT code(s) listed here are in accordance with the 2010 edition of Physicians' Current Procedural Terminology, a publication of the American Medical Association. CPT codes are provided here for the convenience of out clients; however, correct coding often varies from one carrier to another. Consequently, the codes presented here are intended as general guidelines and should not be used without confirming with the appropriate payor that their use is appropriate in each case. All laboratory procedures will be billed to third-party carriers (including Medicare and Medicaid) at fees billed to patients and in accordance with the specific CPT coding required by the intermediary. CPT codes 80002-80019, previously used for automated multichannel testing, have been eliminated as of January 1, 1998. New organ or disease panel CPT codes will be used instead, as noted below. Microbiology CPT code(s) for additional procedures such as susceptibility testing, identification, serotyping, etc. will be billed in addition to the primary codes when appropriate. Barnes Jewish Hospital will process the specimen for a Microbiology test based on source.

ORGAN or DISEASE ORIENTED PANELS

80048 Basic Metabolic Panel
Carbon Dioxide
Chloride
Creatinine
Potassium
Sodium
Urea Nitrogen
Glucose
Calcium

80051 Electrolytes Panel
Carbon Dioxide
Chloride
Potassium
Sodium

80053 Comprehensive Metabolic Panel
Albumin
Bilirubin, Total
Calcium
Carbon Dioxide
Chloride
Creatinine
Alkaline Phosphatase
Potassium
Protein, Total
Sodium
AST (SGOT)
Urea Nitrogen
Glucose
ALT (SGPT)

80055 Obstetric Panel
Complete Blood Count
Hepatitis B surface antigen (HBsAg)
Rubella Antibody IgG
RPR
Type and Screen

80061 Lipid Panel
Cholesterol Total
High Density Cholesterol (HDL)
Triglycerides

80069 Renal Function Panel
Albumin
Calcium
Carbon Dioxide
Chloride
Creatinine
Glucose
Phosphate
Potassium
Sodium
Urea Nitrogen

80074 Acute Hepatitis Panel
Hepatitis A AB IGM
Hepatitis B Core AB IGM
Hepatitis B Surface AG
Hepatitis C AB

80076 Hepatic Function Panel
Albumin
Bilirubin, Total
Alkaline Phosphatase
AST (SGOT)
ALT (SGPT)
Bilirubin Direct
Protein Total

81003 Urine Flex w/Culture
Urine Macroscopic - 81003
Urine Macroscopic *(if indicated)* - 81015
Urine Culture *(if indicated)* - 87086

Urine Reflex
Urine Macroscopic - 81003
Urine Macroscopic *(if indicated)* - 81015

Indicates Reflex Testing Refer to Laboratory Test Catalog

AFP SERUM STUDIES
AFP PROFILE FOUR
AFP - 82105
Estradiol - 82677
hCG - 84702
Inhibin - 86336
AFP PROFILE
AFP - 82105
Estradiol - 82677
hCG - 84702
AFP ONLY
MSAFP - 82105

ANA REFLEX (ANTI-NULEAR AB)
ANA Screen - 86038
ANA Titer *(if appropriate)* - 86039
ds-DNA *(if appropriate)* - 86225

ANTI ANA QUALITATIVE
ANA Screen - 86038
ANA Titer *(if appropriate)* - 86039

CBC EXPRESS – 85027
(No Automated Differential)
- Hematocrit
- Hemoglobin
- Indices
- Platelet Count
- RBC
- WBC

CHLAMYDIA / GC AMPLIFIED PROBE
Probe Amp C. Trachomatis - 87491
Probe Amp N. Gonorrhoeae - 87591

COMPLETE BLOOD COUNT (CBC) – 85025
(With Automated Differential & Platelet Count)
- Five Part Differential
- Hematocrit
- Hemoglobin
- Indices
- Platelet Count
- RBC
- WBC

CULTURE, AEROBE (ROUTINE)
CPT Code is dependent on specimen type.
Routine stool (enteric) culture look for Salmonella and Shigella – 87045
Routine stool (enteric) culture look for additional pathogens – 87046
Routine culture (any source except blood, stool, or urine) – 87070
Routine urine culture (no growth on culture) – 87086
Routine urine culture (growth on culture) – 87088

CULTURE, VIRAL
Culture, Viral – 87252
Shell vial ID each – 87254x2

PROTEIN ELECTRO, REFLEX, SERUM
- Protein Electrophoretic fractionation and quantitation 84165
- Immunoglobulin free light chains (if appropriate) 83883 X2
- Immunofix electrophoresis (if appropriate) 86334

PROTEIN ELECTRO, SERUM
- Protein Electrophoretic fractionation and quantitation 84165
- Immunofix electrophoresis (if appropriate) 86334

O & P EXAM SCREEN
Cryptosporidium Antigen – 87328
Giardia Antigen – 87329
Request O&P Complete Microscopic if comprehensive exam is needed.

ADDITIONAL CPT CODES
O&P Smear & Identification – 87177
Trichrome Stain – 87209

THYROGLOBULIN, TUMOR MARKER
Thyroglobulin - 84432
Thyroglobulin Ab Screen - 86800

THYROID FUNCTION CASCADE
TSH - 84443
FREE T4 *(if appropriate)* - 84439

TYPE AND SCREEN
ABO Typing – 86900
Antibody Screen – 86850
Rh Typing – 86901

Cytology Laboratory Requisition

Date } _____

BARNES-JEWISH Hospital BJC HealthCare

CYTOLOGY LABORATORY REQUISITION

Department of Laboratories • St. Louis, Missouri 63110

PHONE: (314) 362-1470
FAX: (314) 362-5735

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

ORDERING MD / SUBMITTING MD

BILL TO:

☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

SEND ADDITIONAL COPY OF REPORT TO:

CLIENT NUMBER/PHYSICIAN NAME PHONE/FAX NUM.

PHYSICIAN'S ADDRESS CITY, STATE, ZIP

COLLECTION TIME : AM PM COLLECTION DATE MO DAY YR

BJH REGISTRATION #

REGISTERED BY }

PATIENT

PATIENT'S NAME (LAST) (FIRST) (MI) SEX DATE OF BIRTH MO DAY YR PATIENT'S SS #

PATIENT'S ADDRESS CITY STATE ZIP PHONE

REFERENCE # DIAGNOSIS

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ 1-SELF ☐ 2-SPOUSE ☐ 3-CHILD ☐ 4-OTHER

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) SOCIAL SECURITY (INSURED SS#):

ADDRESS OF RESPONSIBLE PARTY APT # DATE OF BIRTH MO DAY YR

CITY STATE ZIP

MEDICAID # STATE MEDICARE # (INCLUDE PREFIX/SUFFIX) ☐ PRIMARY ☐ SECONDARY MEDICARE RETIREMENT OR DISABILITY DATE:

INSURANCE

INSURANCE COMPANY NAME PLAN CARRIER CODE

SUBSCRIBER / MEMBER # LOCATION GROUP #

INSURANCE ADDRESS PHYSICIAN'S PROVIDER #

CITY STATE ZIP

EMPLOYER'S NAME OR NUMBER WORKER'S COMP ☐ YES ☐ NO

CYTOLOGY GYN(PAP SMEAR)

Source: (✔All That Apply)
☐ Vaginal
☐ Ectocervix
☐ Endocervix ☐ EC Brush
☐ Endometrial (Uterine Sample)
☐ Maturation Index (Requires Lateral Vaginal Wall Smear)

Type: (✔One)
☐ Screening
☐ Diagnostic

Slides: (✔One)
☐ 1 Slide
☐ 2 Slides
☐ 3 Slides
☐ More Than 3 slides

Liquid Based
☐ Liquid Pap
☐ Liquid Pap with HPV
☐ Liquid Pap/HPV Reflex Only**

Menstrual Status: LMP (REQUIRED)_____

☐ Regular ☐ Irregular ☐ Pregnant ☐ Post Partum ☐ Lactating

☐ Perimenopausal ☐ Postmenopausal ☐ Post Hysterectomy

Contraceptive Use?	☐ NO	☐ IUD ☐ Hormonal ☐ Other	
Other Hormonal therapy?	☐ NO	☐ YES	_____
Abnormal bleeding?	☐ NO	☐ YES	_____
Previous atypical cytology? *	☐ NO	☐ YES	_____
Previous tumor? *	☐ NO	☐ YES	_____
Treatment History	☐ NO	☐ YES	_____
Infection History	☐ NO	☐ YES	_____
Other Clinical Conditions	☐ NO	☐ YES	_____

* IF YES: type if known_____

**HPV testing will be performed as a reflex order on any liquid pap with a cytologic diagnosis of atypical squamous cells of undetermined significance (ASCUS)

CYTOLOGY: OTHER SOURCES

RESPIRATORY
- ☐ SPUTUM
- ☐ SPUTUM, POST BRONCH.
- ☐ BRONCHIAL WASH _____
- ☐ BRONCHIAL BRUSH _____
- ☐ BAL

URINE
- ☐ BLADDER (VOID)
- ☐ BLADDER (CATH)
- ☐ URETER _____
- ☐ RENAL PELVIS _____
- ☐ FISH BLADDER CA

FLUIDS
- ☐ PERICARDIAL FLUID
- ☐ PERITONEAL FLUID _____
- ☐ PLEURAL FLUID _____
- ☐ CEREBROSPINAL FLUID
- ☐ PELVIC WASHING _____

GASTRIC:
- ☐ BRUSHING_____
- ☐ WASHING_____

ESOPHAGEAL:
- ☐ BRUSHING_____
- ☐ WASHING

☐ FINE NEEDLE ASPIRATION
SITE:

☐ BILIARY TRACT MALIGNANCY FISH TESTING

☐ ANAL RECTAL CYTOLOGY

☐ OTHER (SPECIFY)

_____

Cervicovaginal Cytology (Pap Smear) Disclaimer
The Pap smear is a screening test used to detect cervical cancer and its precursors; it is not a diagnostic procedure. False negative and false positive results do occur. Pap smear results should be interpreted in the context of pertinent clinical information and biopsy results as indicated.

CLINICAL DIAGNOSIS AND HISTORY:

CYTOLOGY #

CLIA 26D0438672

CYTOLOGY

Surgical Pathology Tissue Exam Request

BARNES-JEWISH Hospital
BJC HealthCare

Department of Laboratories
SURGICAL PATHOLOGY TISSUE EXAM REQUEST
St. Louis, Missouri 63110 • (314) 362-0122

Date } _____ Time } _____

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

ORDERING PHYSICIAN

BILL TO:
☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

SEND ADDITIONAL COPY OF REPORT TO:

CLIENT NUMBER/PHYSICIAN NAME PHONE/FAX NUMBER

PHYSICIAN'S ADDRESS CITY, STATE, ZIP

COLLECTION TIME : AM PM COLLECTION DATE MO DAY YR

BJH REGISTRATION #

REGISTERED BY }

PATIENT

PATIENT'S NAME (LAST) (FIRST) (MI) SEX DATE OF BIRTH MO DAY YR PATIENT'S SS #

PATIENT'S ADDRESS CITY STATE ZIP PHONE

REFERENCE # DIAGNOSIS

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ 1-SELF ☐ 2-SPOUSE ☐ 3-CHILD ☐ 4-OTHER

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) SOCIAL SECURITY (INSURED SS#):

ADDRESS OF RESPONSIBLE PARTY APT # DATE OF BIRTH MO DAY YR

CITY STATE ZIP

INSURANCE

MEDICAID # STATE MEDICARE # (INCLUDE PREFIX/SUFFIX) ☐ PRIMARY ☐ SECONDARY MEDICARE RETIREMENT OR DISABILITY DATE

INSURANCE COMPANY NAME PLAN CARRIER CODE

SUBSCRIBER / MEMBER # LOCATION GROUP #

INSURANCE ADDRESS PHYSICIAN'S PROVIDER #

CITY STATE ZIP

EMPLOYER'S NAME OR NUMBER WORKER'S COMP ☐ YES ☐ NO

CLINICAL HISTORY AND DIAGNOSIS:
Patient has metastatic disease? ☐ Yes ☐ No ☐ Unknown ☐ Not Relevant

OB/GYN: Last Menses: Date Ovulation: G: P: AB: Hormone RX:

OPERATIVE PROCEDURE AND FINDINGS:

☐ RUSH (Biopsy only – Must be received prior to 11:00 am Monday-Friday for same day processing)

SPECIMEN: (SPECIFY SITE)

Number of specimens submitted (jars): _____
List specimens here (including SITE of Biopsy):

_____

_____

_____

_____

SUBMITTING MD: (Please Print Clearly) _____ LAST NAME FIRST NAME MIDDLE

ADDITIONAL REPORT TO: _____ LAST NAME FIRST NAME MIDDLE

Additional Report To: (Please Clearly) _____ LAST NAME FIRST NAME MIDDLE

1221-16 (12/08/08)

Prenatal Testing Requisition

PRENATAL TESTING REQUISITION

BARNES-JEWISH Hospital
BJC HealthCare

Clinical Chemistry
1 Barnes - Jewish Hospital Plaza
St. Louis, MO 63110
(314) 362 - 1127

FBR FOUNDATION FOR BLOOD RESEARCH

Shipping Address:
8 Science Park Road
Scarborough, ME 04074

Tel: (207) 883-4131
1-800-639-8605
FAX: (207) 883-1527
www.fbr.org

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

ORDERING PHYSICIAN'S SIGNATURE & UPIN

DUPLICATE REPORT TO

BILL TO:
☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ RESEARCH

ACCOUNT | PATIENT ACCT. | RESEARCH ACCT.

INSURANCE COMPANY NAME MEMBER ID GROUP#

INSURANCE ADDRESS

CITY STATE ZIP

EMPLOYER NAME/EMPLOYER # | INSURED SSN (IF NOT PATIENT)

PATIENT INFORMATION

SSN — —

PHONE ( ) —

PATIENT NAME: LAST, FIRST MIDDLE

DATE OF BIRTH

SEX M F

SAMPLE TYPE ☐ Serum ☐ Fluid

SAMPLE DRAW DATE

REFERRING DOCTOR

TIME ☐ AM ☐ PM

INITIALS _____

BJC REGISTRATION #

REGISTRATION BY

ACCESSION NUMBER

DIAGNOSIS text or ICD9 codes

REFERENCE NO.

☐ CARE PARTNERS ☐ HEALTH PARTNERS ☐ OTHER (complete below)

RELATIONSHIP TO INSURED
☐ SELF ☐ SPOUSE ☐ DEPENDENT

MEDICARE NUMBER SUFFIX

MEDICAID NUMBER STATE

CHECK TEST(S) REQUESTED

SERUM AFP STUDIES (complete part A)

☐ **AFP PROFILE FOUR** (AFP, Estriol, hCG, Inhibin)

☐ **AFP ONLY - for Neural Tube Defect screening only**

SST FOR BLOOD STUDIES

AMNIOTIC FLUID STUDIES (complete part B)

☐ **AMNIOTIC FLUID AFP**
Plus reflexive ACHE and Blood Contamination studies if indicated
☐ Omit reflexive testing and associated additional charges

☐ **ACETYLCHOLINESTERASE (ACHE) priority study**
Includes amniotic fluid AFP and Contamination Studies if indicated

PART A

Is this test a repeat? Y N

LMP date: ____ /____ /____ **U/S date:** ____ /____ /____ GA on U/S date: _____ wks. _____ days ☐ Check box if by BPD.

Height: _____ Current **weight** (lbs.): _____

Race: ☐ Caucasian ☐ Black ☐ Other

Pregnancy History: Vaginal bleeding this pregnancy? Y N

Cigarette smoker? Y N If yes, how many per day? _____

Has the patient had...

☐ Amniocentesis? or ☐ CVS? date ____ /____ /____

☐ First trimester test for Down syndrome? date ____ /____ /____

Insulin dependent diabetic prior to this pregnancy? Y N

Multiple pregnancy? Y N If yes, number of fetuses: _____

IVF this pregnancy? Y N If donor egg, age of donor: _____

Previous pregnancy diagnosed to have Down syndrome? Y N

Family history: Spina bifida, Anencephaly, or Hydrocephaly? Y N

If yes, describe:

PART B

REASON FOR AMNIOCENTESIS

☐ Elevated serum AFP ☐ Abnormal U/S (explain)
☐ Screen positive for DS ☐ History of NTD ☐ History of chromosome disorders
☐ Advanced maternal age ☐ Other (specify)

COMMENTS

LMP date: ___/___/___ If U/S, _____ wks GA on date: ___/___/___

This specimen is: ☐ supernatant ☐ whole fluid Is it blood stained? Y N

FBR COPY

Vers. 3/08

Molecular Diagnostic Laboratory Request for DNA Studies-Medical Genetics

MOLECULAR DIAGNOSTIC LABORATORY
Washington University School of Medicine
Barnes-Jewish Hospital-North Campus Room 2320
Mailstop #90-35-709
216 South Kingshighway, St. Louis, MO 63110
(314) 454-8685; (314) 454-7601; FAX (314) 454-7616
URL: http://pathology.wustl.edu/patientcare/moldiagnostic.php

BARNES-JEWISH Hospital
BJC HealthCare

Request For DNA Studies
MEDICAL GENETICS

COLLECTION INFORMATION: ☐ AM ☐ PM
DATE _____ TIME _____ INITIALS _____

ACCOUNT INFORMATION

NAME
ADDRESS
CITY STATE ZIP
PHONE
FAX
ORDERING PHYSICIAN
SECOND REPORT TO

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.

THIS SECTION FOR LAB USE ONLY

PATIENT ID } NO. SPEC RECEIVED } REGISTERED BY } VERIFIED BY }

PATIENT INFORMATION

PATIENT LAST NAME OR ID#	FIRST	DOB	SEX

ADDRESS	SSN

CITY	STATE	ZIP	PHONE

ICD9 CODE } REFERENCE NO. }

BILLING INFORMATION } **BILL TO:** ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ☐ Medicaid ☐ CARE PARTNERS ☐ PARTNERS HMO
ID #_____ ALPHA Code_____ ☐ GHP ☐ OTHER_____

INSURANCE CO.	I.D.#
ADDRESS	GRP.#
INSURED NAME (IF NOT PATIENT)	PLAN NAME

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits.

Laboratory Use Only:

Specimen Condition: _____
Specimen Number: _____
Date Received: _____ Time Received: _____

Tube Type:
☐ EDTA
☐ ACD
☐ OTHER: _____

For Children: Father's Name: _____ City: _____
Mother's Name: _____ State: _____ Zip Code: _____

Diagnostic Test:

- ☐ Angelman Syndrome (5944)
- ☐ Beckwith-Wiedemann Syndrome (5945)
- ☐ Cystic Fibrosis (5905)
- ☐ Factor 5 Leiden (FVL) Mutation (5946)
- ☐ Fragile X Syndrome (5847)
- ☐ LCHAD (5934)
- ☐ MCAD (5909)
- ☐ Prader-Willi Syndrome (5944)
- ☐ Prothrombin (Factor 2) Mutation (5953)
- ☐ *RET* (MEN2/FMTC) Comp (5793)
- ☐ *RET* Follow-up (5794)
- ☐ Russell-Silver Syndrome
- ☐ Fragile X-Associated Tremor & Ataxia Syndrome FXTAS (3392)
- ☐ Warfarin Sensitivity (CYP2C9, VKORC1)

Reason for Study: ☐ Diagnostic Testing ☐ Carrier Detection ☐ Prenatal Diagnosis ☐ Routine ☐ STAT

☐ Has genetic counseling by an authorized person been offered? (5946, 5953, and Warfarin exempted)
☐ Has informed consent been obtained from the consultant and/or guardian?
☐ Has genetic counseling by an authorized person been offered?

For CF Study Only: Ethnic Origins: Father: _____ Mother: _____

Please enter a short pedigree and any other clinical information below

DNA STUDY/MEDICAL GENETICS

Molecular Diagnostic Laboratory Request for DNA Studies-Oncology

MOLECULAR DIAGNOSTIC LABORATORY
Washington University School of Medicine
Barnes-Jewish Hospital-North Campus Room 2320
Mailstop #90-35-709
216 South Kingshighway, St. Louis, MO 63110
(314) 454-8685, 454-7601; FAX (314) 454-7616
URL: http://pathology.wustl.edu/patientcare/moldiagnostic.php

BARNES-JEWISH Hospital BJC HealthCare

Request For DNA Studies
ONCOLOGY

COLLECTION INFORMATION: ☐ AM ☐ PM
DATE _____ TIME _____ INITIALS _____

ACCOUNT INFORMATION

NAME
ADDRESS
CITY STATE ZIP
PHONE
FAX
ORDERING PHYSICIAN
SECOND REPORT TO

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.

PATIENT INFORMATION

PATIENT LAST NAME OR ID#	FIRST	DOB	SEX

ADDRESS			SSN
CITY	STATE	ZIP	PHONE

NARRATIVE DIAGNOSIS } REFERENCE NO. }

BILLING INFORMATION } BILL TO: ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ☐ Medicaid ☐ CARE PARTNERS ☐ PARTNERS HMO
ID # ALPHA Code _____ ☐ GHP ☐ OTHER _____

INSURANCE CO.	I.D. #
ADDRESS	GRP. #
INSURED NAME (IF NOT PATIENT)	PLAN NAME
PATIENT ID }	NO. SPEC RECEIVED }
REGISTERED BY }	VERIFIED BY }

LAB USE ONLY

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits.

Laboratory Use Only:

Specimen Condition: _____
Specimen Number: _____
Date Received: _____
Time Received: _____

☐ Patient ☐ Donor for:_____
☐ Pre-BMT ☐ Post-BMT
☐ Allogenic ☐ Autologous

Sample Type:
☐ BM
☐ PB Whole
☐ PB T Lymphocytes
☐ PB Myeloid cells
☐ Lymph node
☐ Other:_____

Tube Type:
☐ Sodium EDTA
☐ ACD
☐ Paraffin Embedded
☐ Frozen
☐ Other:_____

☐ Alveolar Rhabdomyosarcoma Translocation (PAX) (5958)
☐ BCL2 (t(14;18)) (5859)
☐ BCR/ABL1 (ALL, CML) qualitative (5441)
☐ BCR/ABL1 (CML) quantitative (5442)
☐ Desmoplastic Small Round Cell Tumor Translocation (DSRCT) (5954)
☐ Dyskeratosis Congenita (hTERC) (5500)
☐ Ewing's Sarcoma Translocation (EWS, PNET) (5956)
☐ FLT3 (5951)
☐ IGH Hypermutation (IGHV) (5515)
☐ IGH Rearrangement (B cell Clonality) (5856)
☐ JAK2 (V617F)
☐ NPM1
☐ PML-RARα (t(15;17)) (5706)
☐ Post-BMT STR Engraftment (5796)
☐ Post-BMT STR-Separated PB cells (Chimerism) (5954)
☐ Pre-BMT STR Patient
☐ Pre-BMT STR Donor
☐ Synovial Sarcoma Translocation (5960)
☐ TCR Gamma Rearrangement (5952)
☐ Thymidylate Synthase/ 5-FU Response (5948)
☐ TCR Beta Rearrangement (5857)
☐ UGT1A1 (9933)
☐ Other (Prior Lab approval req'd)

Clinical Information:

Studies cannot be completed without adequate patient identification and requested clinical information.

BJC HEALTHCARE SYSTEM

Barnes-Jewish Hospital
Flow Cytometry
Dept. of Laboratories

Flow Cytometry Immunophenotyping Request

Patient Name: _____ **Date:** _____

Hospital #: _____ **Room#:** _____

D.O.B: _____

Doctor: _____ **Beeper #:** _____

Specimen Type:

- ☐ Peripheral Blood (1 lavender-top [EDTA] tube and 2 green-top [heparin] tubes)- See below for draw requirements for PNH
- ☐ Bone Marrow (1 green-top [heparin] tube)
- ☐ Fluid:
- ☐ Tissue:
- ☐ Other:

Date and Time Obtained: _____

Diagnosis (REQUIRED): _____

Ruleout: _____

Test Requested:

- ☐ Lymphoma WorkUp (Lymphoproliferative disorder ex: CLL, NHL, HCL)
- ☐ Leukemia WorkUp (Acute Leukemia ex AML, ALL, ANLL)
- ☐ PNH Profile Includes RBC-CD59, WBC-CD59 and FLAER (1 lavender-top [EDTA] tube and 1 green-top [heparin] tube)
- ☐ Sezary Cell Workup
- ☐ Other (Please Specify)

If you have any question please call the Barnes-Jewish Flow Cytometry Lab at 362-4628!!

Allergen Test Request Form (Page 1)

Date } _____

BARNES-JEWISH Hospital

ALLERGEN TEST REQUEST FORM

Department of Laboratories • St. Louis, Missouri 63110

PHONE: (314) 362-1470
FAX: 314-362-5735

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP

PHONE

ORDERING PHYSICIAN

BILL TO:
☐ ACCOUNT ☐ PATIENT/INSURANCE ☐ ALTERNATE

SEND ADDITIONAL COPY OF REPORT TO:

CLIENT NUMBER/PHYSICIAN NAME PHONE/FAX NUM.

PHYSICIAN'S ADDRESS CITY, STATE, ZIP

COLLECTION TIME : AM PM | FASTING YES ☐ NO ☐ | COLLECTION DATE MO DAY YR | URINE hrs/vol hrs_____ vol_____

☐ **STAT** CALL RESULTS TO: (#_____) COMPLETE AND ATTACH STAT FLYER

BJH REGISTRATION #

REGISTERED BY }

PATIENT

PATIENT'S NAME (LAST) (FIRST) (MI) SEX DATE OF BIRTH MO DAY YR PATIENT'S SS #

PATIENT'S ADDRESS CITY STATE ZIP PHONE

REFERENCE # DIAGNOSIS

REQUIRED

RESP. PARTY

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ■ 1-SELF ■ 2-SPOUSE ■ 3-CHILD ■ 4-OTHER

NAME OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) SOCIAL SECURITY (INSURED SS#):

ADDRESS OF RESPONSIBLE PARTY APT # DATE OF BIRTH MO DAY YR

CITY STATE ZIP

MEDICAID # STATE MEDICARE # (INCLUDE PREFIX/SUFFIX) ☐ PRIMARY ☐ SECONDARY MEDICARE RETIREMENT OR DISABILITY DATE:

INSURANCE

INSURANCE COMPANY NAME PLAN CARRIER CODE

SUBSCRIBER / MEMBER # LOCATION GROUP #

INSURANCE ADDRESS PHYSICIAN'S PROVIDER #

CITY STATE ZIP

EMPLOYER'S NAME OR NUMBER WORKER'S COMP ☐ YES ☐ NO

ROUTINE PROFILES 0.1 mL SERUM PER ALLERGEN

ALLERGY TEST REQUEST PANELS (see back for details)

☐ MO/ILL REGIONAL SCREEN ☐ FOOD SCREEN

INDIVIDUAL ALLERGENS 0.1 mL SERUM PER ALLERGEN

COMMON ALLERGENS

WEEDS
- ☐ W1 Common ragweed (short)
- ☐ W17 Firebrush (Kochia)
- ☐ W10 Lamb's quarters
- ☐ W14 Rough pigweed
- ☐ W2 Western ragweed, Giant ragweed (tall), English Plantain

TREES
- ☐ T14 Cottonwood tree
- ☐ T8 Elm tree
- ☐ T1 Maple (box elder)
- ☐ T6 Mountain juniper
- ☐ T7 Oak tree
- ☐ T22 Pecan
- ☐ T10 Walnut tree
- ☐ T15 White ash tree
- ☐ T16 White pine tree
- ☐ T12 Willow tree

HOUSE DUST MITES
- ☐ Dermatoph. Farinae
- ☐ Dermatoph. Microceras
- ☐ Dermatoph. Pteronyssimus

INSECTS & VENOMS
- ☐ Cockroach
- ☐ Common wasp (yellow jacket)
- ☐ Fire ant
- ☐ Honey Bee
- ☐ Paper wasp
- ☐ White faced hornet
- ☐ Yellow hornet

DRUGS
- ☐ C1 Penicilloyl G
- ☐ C2 Penicilloyl V

HOUSE DUST
- ☐ H1 House dust - Greer
- ☐ H2 House dust - Hollister-Stier

GRASSES
- ☐ G2 Bermuda grass
- ☐ G15 Cultivated wheat pollen
- ☐ G10 Johnson grass
- ☐ G8 June grass (Kent, blue)
- ☐ G4 Meadow fescue
- ☐ G5 Perennial rye grass
- ☐ G9 Red top (Bent grass)
- ☐ G1 Sweet vernal grass
- ☐ G6 Timothy grass

EPIDERMALS
- ☐ E1 Cat dander
- ☐ E5 Dog dander
- ☐ E2 Dog epithelium
- ☐ E3 Horse dander

MOLD
- ☐ M6 Alternaria tenuis
- ☐ M3 Aspergillus Fumigatus
- ☐ M7 Botrytis cinerea

MOLD (cont'd.)
- ☐ M2 Cladosporium Herbarium
- ☐ M9 Fusarium moniliform
- ☐ M1 Penicillium Notatum
- ☐ M13 Phoma Betae

FOOD
- ☐ F20 Almond
- ☐ F45 Baker's yeast
- ☐ F6 Barley
- ☐ F18 Brazil nut
- ☐ F11 Buckwheat
- ☐ F85 Celery
- ☐ F83 Chicken meat
- ☐ F36 Coconut
- ☐ F3 Codfish
- ☐ F1 Egg White
- ☐ F75 Egg Yolk
- ☐ F47 Garlic
- ☐ F17 Hazel nut
- ☐ F91 Mango

FOOD (cont'd.)
- ☐ F87 Melons
- ☐ F2 Milk
- ☐ F7 Oat
- ☐ F33 Orange
- ☐ F13 Peanut
- ☐ F35 Potato
- ☐ F5 Rye
- ☐ F41 Salmon
- ☐ F10 Sesame seed
- ☐ F14 Soybean
- ☐ F44 Strawberry
- ☐ F25 Tomato
- ☐ F40 Tuna
- ☐ F4 Wheat

SHELL FISH
- ☐ F37 Blue mussel
- ☐ F23 Crab
- ☐ F80 Lobster
- ☐ F24 Shrimp

INDIVIDUAL ALLERGENS 0.1 mL SERUM PER ALLERGEN CONTINUED

SPECIALIZED ALLERGENS LIST

FOOD
- ☐ f76 alpha-lactalbumin
- ☐ f49 Apple
- ☐ f27 Beef
- ☐ f77 b-Lactoglobulin
- ☐ f31 Carrot
- ☐ f78 Casein
- ☐ f81 Cheese cheddar type
- ☐ f82 Cheese, mould type
- ☐ f79 Gluten
- ☐ f84 Kiwi fruit
- ☐ f8 Maize
- ☐ f89 Mustard
- ☐ f88 Mutton
- ☐ f86 Parsley
- ☐ f12 Pea
- ☐ f9 Rice
- ☐ f15 White beans

MOLDS
- ☐ m12 Aureobasidium pullulans
- ☐ m5 Candida albicans (yeast)
- ☐ m16 Curvularia lunata
- ☐ m14 Epicoccum purpurasen
- ☐ m4 Mucor racemosus
- ☐ m11 Rhizopus nigricans
- ☐ m10 Stermphylium botryosum
- ☐ m15 Trichoderma viride

PARASITES AND INSECTS
- ☐ p1 Ascaris
- ☐ p2 Echinococcus
- ☐ i71 Mosquito

WEEDS
- ☐ w13 Cocklebur
- ☐ w8 Dandelion
- ☐ wC4 False ragweed
- ☐ w12 Golden Rod
- ☐ w15 Lenscale
- ☐ w6 Mugwort
- ☐ w20 Nettle
- ☐ w7 Ox-eye daisy

WEEDS (cont'd.)
- ☐ w16 Rough Marshelder
- ☐ w11 Russian thistle
- ☐ w18 Sheep sorrel
- ☐ w19 Wall pellitory
- ☐ w5 Wormwood

EPIDERMAL / ANIMAL PRO.
- ☐ e77 Budgerigar droppings
- ☐ e78 Budgerigar feathers
- ☐ e79 Budgerigar, serum proteins
- ☐ e4 Cow dander
- ☐ e86 Duck feathers
- ☐ e80 Goat epithelium
- ☐ e70 Goose feathers
- ☐ e6 Guinea pig epithelium
- ☐ e84 Hamster epithelium
- ☐ e76 Mouse, serum proteins
- ☐ e72 Mouse, urine proteins
- ☐ e82 Rabbit epithelium
- ☐ e75 Rat, serum proteins
- ☐ e74 Rat, urine proteins
- ☐ e81 Sheep epithelium
- ☐ e83 Swine epithelium

GRASS POLLENS
- ☐ g17 Bahia grass
- ☐ g11 Brome grass
- ☐ g71 Canary grass
- ☐ g3 Cocksfoot
- ☐ g7 Common reed
- ☐ g14 Cultivated oat
- ☐ g12 Cultivated rye
- ☐ g16 Meadow foxtail
- ☐ g13 Velvet grass
- ☐ g70 Wild rye grass

OCCUPATIONAL ALLERGENS
- ☐ k82 Latex

TREE POLLENS
- ☐ t19 Acacia
- ☐ t5 American beech
- ☐ t73 Australian pine
- ☐ Rt206 Chestnut
- ☐ t3 Common silver birch
- ☐ t14 Cottonwood, Poplar
- ☐ Rt207 Douglas fir
- ☐ Rt205 Elder tree

TREE POLLENS (cont'd.)
- ☐ t18 Eucalyptus, Gum-tree
- ☐ t2 Grey alder
- ☐ t4 Hazel
- ☐ Rt209 Horn Beam
- ☐ Rt203 Horse Chestnut
- ☐ t23 Italian cypress
- ☐ Rt208 Linden tree
- ☐ t21 Melaleuca Cajeput-tree
- ☐ t20 Mesquite
- ☐ t70 Mulberry
- ☐ t9 Olive
- ☐ Rt210 Privat
- ☐ t72 Queen palm
- ☐ Rt201 Spruce
- ☐ t15 White ash
- ☐ t16 White pine
- ☐ t12 Willow

Allergen Test Request Form (Page 2)

MO/ILL REGIONAL SCREEN 14 TESTS	FOOD SCREEN - 11 TESTS
Dermatoph. pteronyssimus	Tuna
Dermatoph. farinae	Egg White
House Dust - Hollister-Stier	Milk
Cat Dander	Orange
Dog Dander	Peanut
Bermuda Grass	Chicken
Rye Grass	Potato
Timothy	Sesame
Cladosporium herbarum	Soybean
Alternaria tenuis	Tomato
Maple (Box Elder)	Wheat
Oak	
Elm	
Ragweed	

Centers for Disease Patient History Form (Page 1)

*Justification must be completed by State health department laboratory before specimen can be accepted by CDC. Please check the first applicable statement and when appropriate complete the statement with the *.*

1. Disease suspected to be of public health importance. Specimen is:
   (a) ☐ from an outbreak. (b) ☐ from uncommon or exotic disease.
   (c) ☐ an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d) ☐ from a disease for which reliable diagnostic reagents or expertise are unavailable in State.
2. ☐ Ongoing collaborative CDC/State project.
3. ☐ Confirmation of results requested for quality assurance.

*Prior arrangement for testing has been made.
Please bring to the attention of:

(Name): _____

Completed by:

_____

Date: __ __/__ __/__ __ __ __

Name, Address and Phone Number of Physician or Organization:

STATE HEALTH DEPARTMENT LABORATORY ADDRESS:

STATE HEALTH DEPT. NO.: _____

DATE SENT TO CDC: (MM/DD/YYYY) __ __/__ __/__ __ __ __

PATIENT IDENTIFICATION: (Hospital No.) _____

NAME: (LAST, FIRST, MI) _____

BIRTHDATE: (MM/DD/YYYY) __ __/__ __/__ __ __ __ **SEX:** ☐ MALE ☐ FEMALE

CLINICAL DIAGNOSIS: _____

ASSOCIATED ILLNESS: _____

DATE OF ONSET: (MM/DD/YYYY) __ __/__ __/__ __ __ __ **FATAL?** ☐ YES ☐ NO

(FOR CDC USE ONLY) UNIT	FY	CDC NUMBER NUMBER	SUF	DATE RECEIVED MO DA YR
				__ __/__ __/__ __ __ __

REVERSE SIDE OF THIS FORM MUST BE COMPLETED

THIS FORM MUST BE EITHER PRINTED OR TYPED
PLEASE PREPARE A SEPARATE FORM FOR EACH SPECIMEN

D.A.S.H.

0	3

DATE REPORTED
MO DA YR
__ __/__ __/__ __ __ __

Comments:

D	6	5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
Center for Infectious Diseases
Atlanta, Georgia 30333

Centers for Disease Patient History Form (Back)

LABORATORY EXAMINATION(S) REQUESTED:
- ☐ ANtimicrobial Susceptibility ☐ ISolation
- ☐ SErology (Specific Test) _____
- ☐ HIstology
- ☐ IDentification ☐ OTher (Specify) _____

CATEGORY OF AGENT SUSPECTED:
- ☐ BActerial ☐ RIckettsial
- ☐ VIral ☐ PArasitic
- ☐ FUngal ☐ OTher (Specify) _____

SPECIFIC AGENT SUSPECTED:	OTHER ORGANISM(S) FOUND:	ISOLATION ATTEMPTED? ☐ YES ☐ NO	NO. OF TIMES ISOLATED:	NO. OF TIMES PASSED:	SPECIMEN SUBMITTED IS: ☐ Original Material ☐ Mixed Isolate ☐ Pure Isolate

DATE SPECIMEN TAKEN: __ __/__ __/__ __ __ __ (MO DA YR)

ORIGIN: ☐ FOod ☐ ANimal ☐ HUman ☐ SOil (Specify) _____ ☐ OTher (Specify) _____

SOURCE OF SPECIMEN:
- ☐ BLood ☐ CSF ☐ WOund (Site) _____
- ☐ GAstric ☐ HAir ☐ EXudate (Site) _____
- ☐ SErum ☐ SKin ☐ TIssue (Specify) _____
- ☐ SPutum ☐ STool ☐ OTher (Specify) _____
- ☐ URine ☐ THroat

SUBMITTED ON:
- ☐ MEdium _____
- ☐ ANimal _____
- ☐ TIssue Culture (Type) _____
- ☐ EGg ☐ OTher (Specify) _____

SERUM INFORMATION: (MO DA YR)
- ☐ ACute __ __/__ __/__ __ __ __
- ☐ COnvalescent __ __/__ __/__ __ __ __
- ☐ S3 __ __/__ __/__ __ __ __
- ☐ S4 __ __/__ __/__ __ __ __
- ☐ S5 __ __/__ __/__ __ __ __

IMMUNIZATIONS: (MO YR)
- (1.) _____ __ __/__ __ __ __
- (2.) _____ __ __/__ __ __ __
- (3.) _____ __ __/__ __ __ __
- (4.) _____ __ __/__ __ __ __

TREATMENT: DRUGS USED ☐ None

	DATE BEGUN (MO DA YR)	DATE COMPLETED (MO DA YR)
(1.) _____	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
(2.) _____	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
(3.) _____	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __

EPIDEMIOLOGICAL DATA:
- ☐ SIngle Case ☐ SPoradic ☐ COntact ☐ EPidemic ☐ CArrier
- Family Illness _____
- Community Illness _____

Travel and Residence (Location)
- ☐ Foreign _____
- ☐ USA _____
- Animal Contacts (Species) _____
- Anthropod Contacts: ☐ None ☐ Exposuer Only ☐ Bite
- Type of Anthropod: _____
- Suspected Source of Infection: _____

SIGNS AND SYMPTOMS:
- ☐ FEver
  - Maximum Temperature: _____
  - Duration: _____ Days
- ☐ CHills

SKIN:
- ☐ MAculopapular
- ☐ HEmorrhagic
- ☐ VEsicular
- ☐ Erythema Nodosum
- ☐ Erythema Marginatum
- ☐ OTher _____

RESPIRATORY:
- ☐ RHinitis
- ☐ PUlmonary
- ☐ PHaryngitis
- ☐ CAlcifications
- ☐ Otitis Media
- ☐ PNeumonia (type)
- ☐ OTher _____

CARDIOVASCULAR:
- ☐ MYocarditis
- ☐ PEricarditis
- ☐ ENdocarditis
- ☐ OTher _____

GASTROINTESTINAL:
- ☐ DIarrhea
  - ☐ BLood
  - ☐ MUcous
- ☐ COnstipation
- ☐ ABnormal Pain
- ☐ VOmiting
- ☐ OTher _____

CENTRAL NERVOUS SYSTEM:
- ☐ HEadache
- ☐ MEningismus
- ☐ MIcrocephalus
- ☐ HYdrocephalus
- ☐ SEizures
- ☐ CErebral Calcification
- ☐ CHorea
- ☐ PAralysis
- ☐ OTher _____

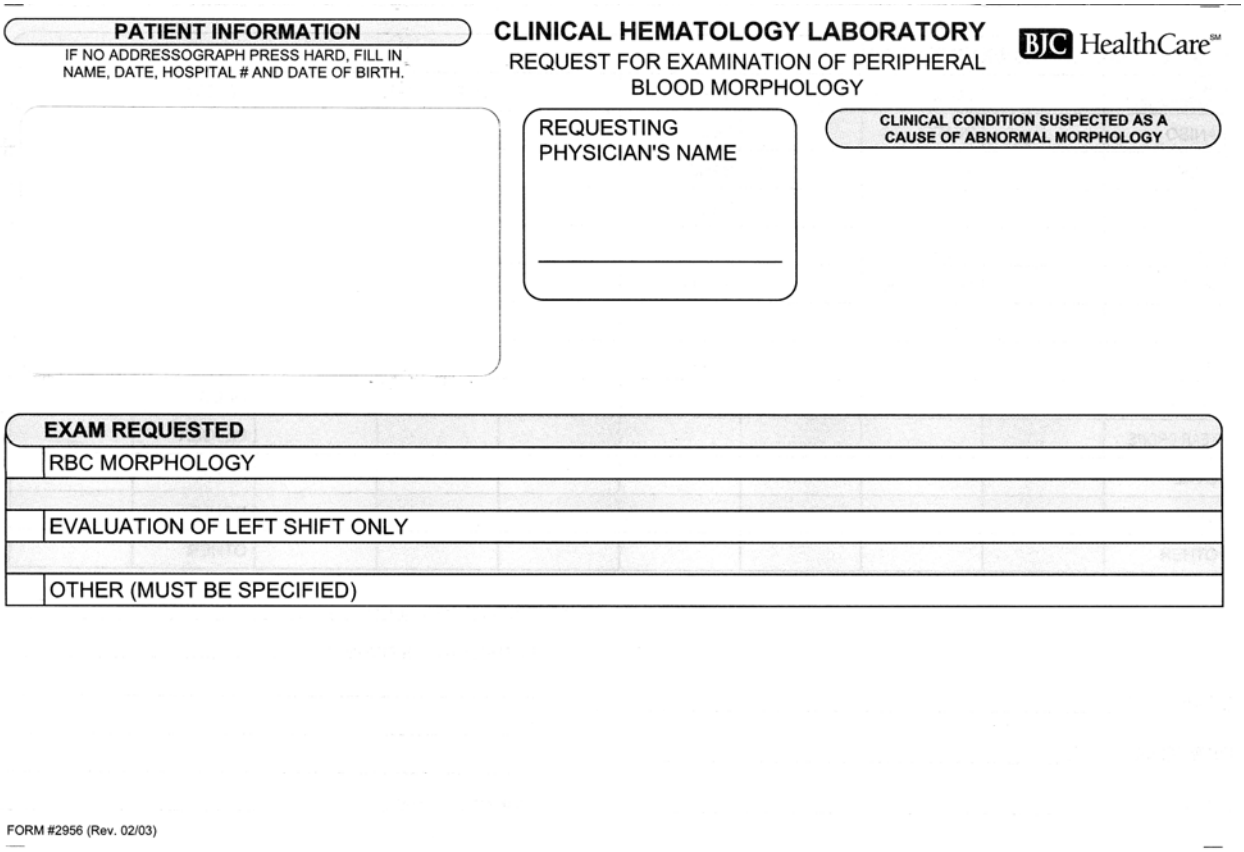
MISCELLANEOUS:
- ☐ JAundice
- ☐ MYalgia
- ☐ PLeurodynia
- ☐ COnjunctivitis
- ☐ CHorioretinitis
- ☐ SPlenomegaly
- ☐ HEpatomegaly
- ☐ LIver Abscess/cyst
- ☐ LYmphadenopathy
- ☐ MUcous Membrane Lesions
- ☐ OTher _____

STATE OF ILLNESS:
- ☐ SYmptomatic
- ☐ ASymptomatic
- ☐ SUbacute
- ☐ CHronic
- ☐ DIsseminated
- ☐ LOcalized
- ☐ EXtraintestinal
- ☐ OTher _____

PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION: (Information supplied should be related to this case and/or specimen(s) and relative to the test(s) requested.

CDC NUMBER	UNIT	FY	NUMBER	SUF

Clinical Hematology Laboratory Request for Examination of Peripheral Blood Morphology (Front)



PATIENT INFORMATION
IF NO ADDRESSOGRAPH PRESS HARD, FILL IN NAME, DATE, HOSPITAL # AND DATE OF BIRTH.

CLINICAL HEMATOLOGY LABORATORY
REQUEST FOR EXAMINATION OF PERIPHERAL BLOOD MORPHOLOGY

BJC HealthCare℠

REQUESTING PHYSICIAN'S NAME

CLINICAL CONDITION SUSPECTED AS A CAUSE OF ABNORMAL MORPHOLOGY

EXAM REQUESTED

- ☐ RBC MORPHOLOGY
- ☐ EVALUATION OF LEFT SHIFT ONLY
- ☐ OTHER (MUST BE SPECIFIED)

FORM #2956 (Rev. 02/03)

Clinical Hematology Laboratory Request for Examination of Peripheral Blood Morphology (Back)

MORPHOLOGICAL EXAMINATION

RBC MORPHOLOGY		TARGET CELLS		GRANULOCYTES		LYMPHOCYTES		MONOCYTES	
ANISO		PLATELETS		SEG.		LYMPH		MONO	
POIK		SICKLE CELLS		BAND		BLYMPH		Y MONO	
POLY		PLAT. EVAL.		META		PROLYMPH			
HYPO		PLAT. ENLARGE		MYELO		ATLYMPH			
MACRO		MEG. K. FR.		PROG		ABLYMPH			
MICRO		PLAT. CLUMPS		EOS				OTHER SIGNIFICANT FINDINGS	
HJB				BASO				BLAST	
BURR								NRBC	
TEAR DROPS								PELGER	
OVAL								AUER	
BAST								DOHLE	
OTHER								OTHER	

FINDING(S) IN QUESTION _____

PATHOLOGIST'S FINDINGS _____

SAMPLE # _____

PERFORMED BY _____

DATE _____

SIGNATURE / DATE: _____