Request Forms

NetworkReferenceLab **Cytology Request Form**

SEND REPORT TO

NetworkReferenceLab
11133 Dunn Road
St. Louis, Missouri 63136
(314) 653-4455

Patient Information: (I.D.#)

PLEASE PRINT

Patient's Last Name | First Name | MI
Birthdate / / | Age | Sex | SS# – –
Address
State | Zipcode | Patient's Phone # ( ) | PCP
Name of Responsible Party (If Different From Patient) Last Name | MI
Address of Responsible Party
Patient's Relationship To Responsible Party ☐ 1-Self ☐ 2-Spouse ☐ 3-Child ☐ 4-Other
Ordering Physician (if other than PCP)

Bill to:
☐ Aetna PPO, POS, OpenAccess, EPO, NAP, MC
☐ Alliance Blue Cross
☐ Alliance Choice Blue Cross
☐ Cigna PPO
☐ First Health PPO
☐ Healthcare USA MC+
(PLEASE ATTACH COPY OF INSURANCE CARD)
☐ Healthlink PPO
☐ Health Link BJC Employees Gold, Silver, Bronze
☐ Hospital/Clinic
☐ IDPA
☐ Medicaid
☐ Medicare
☐ Mercy-Commercial
☐ Patient
☐ Physician's Office
☐ United Health Care
☐ Other _____

Medicare # ☐ Primary ☐ Secondary | Suffix – –
Medicaid # | State
Ins. Address | Group # | Cert. #
Insured Name | Employer (Name or Number)
Insured SS# (If not patient) – – | Worker's Comp ☐ Yes ☐ No
Secondary Insurance Plan

PRESS HARD–2 COPIES **CYTOLOGY**

NRL/Reg #_____ Reg by_____

DIAGNOSIS / SIGN / SYMPTOM / ICD 9 CODES: All requested laboratory tests must have documented medical necessity. Please provide ICD 9 codes for highest digit for diagnosis, signs, symptoms for medical necessity in the numbered spaces.

1. _____ 3. _____
2. _____ 4. _____

MEDICARE AND MEDICAID PATIENTS ONLY: Please check one only

☐ Screening PAP - Laboratory examination screening for malignant neoplasm, cervix (well woman). Medicare patients only: reimbursable once every 2 years.

☐ Diagnostic PAP - Laboratory examination, other personal history presenting hazards to healthy; high risk of cervical cancer, history of abnormality or signs or symptoms of medical necessity. Physician recommends screening more often than every two years based on medical history.

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.

Collection Date:_____/_____/_____

GYN CYTOLOGY:

☐ **CERVICAL** ☐ **ENDOCERVICAL** ☐ **VAGINAL** **Please mark all appropriate boxes for testing**

☐ **LIQUID-BASED PAP TEST** with reflex to high risk HPV testing for ASCUS diagnosis ☐ **LIQUID-BASED PAP TEST** with high risk HPV test

☐ **LIQUID-BASED PAP TEST** only ☐ **HIGH RISK HPV TEST** only (No Pap) ☐ **TRADITIONAL PAP SMEAR** ☐ 1 Slide ☐ 2 Slides

AMPLIFIED NUCLEIC ACID TESTING from liquid-based vial: ☐ GC/CHLAMYDIA ☐ GC ONLY ☐ CHLAMYDIA ONLY

NON-GYN CYTOLOGY:

☐ FNA, specify site:_____

☐ Urine, specify: ☐ Voided ☐ Catheterized

☐ Breast Nipple Discharge, specify site: ☐ Right ☐ Left

APPLICABLE TO ALL PATIENTS:

PERTINENT HISTORY (check all that apply)

☐ Routine Check Up
☐ Pregnant
☐ Postpartum
☐ Post Menopausal
☐ Hormonal Therapy _____
☐ Depo Provera
☐ Abnormal Bleeding
☐ Hysterectomy, please specify
☐ Total ☐ Supra-Cervical
☐ IUD
L.M.P. _____

PREVIOUS PAP TEST

☐ Negative - Date _____
☐ Abnormal - Date/Diagnosis _____
_____

PREVIOUS SURGICAL FINDINGS

Date_____ Results _____
_____
_____

Clinical findings at exam: _____
_____

☐ MANDATORY PATHOLOGIST REVIEW

Gregory S. King, M.D. • Jeffrey Edelman, M.D. • Steven Johnson, M.D. • Marilyn Johnston, M.D. • Olaronke Ogunremi, M.D. • Susan Rayne, M.D. • John Rollo, M.D. • Mary A. Rudloff, M.D.

CH 386 (10/05/09)

NetworkReferenceLab **General Request Form**

NetworkReferenceLab
11133 Dunn Road
St. Louis, Missouri 63136

Phone: (314) 653-4455
1-800-533-7720
Fax: (314) 653-4156

Patient Information: (I.D.#)
PLEASE PRINT

Patient's Last Name | First Name | MI
Birthdate / / | Age | Sex | SS# – –
Address
Patient's Phone # ( ) | PCP | Room #
Name of Responsible Party (If Different From Patient) Last Name | MI
Address of Responsible Party
Patient's Relationship To Responsible Party ☐ 1-Self ☐ 2-Spouse ☐ 3-Child ☐ 4-Other
Ordering Physician (If other than PCP)

Physician's Signature
Nurse's Signature _____ Beeper # _____
☐ STAT Assay ☐ Fax Results/No. _____
☐ Phone Results To: ☐ Exch. _____ Office _____
☐ Send Additional Copies To: _____

Collection Date:___/___/___ Time:_____ Fasting: ☐ Yes ____hrs. ☐ No
Location of Draw: ☐ NE ☐ NEPOB1 ☐ NEPOB2 ☐ NWHC ☐ GMC ☐ Other Initials_____
Tubes: __ Purple __ Lt Green __ Red __ Blue __ Gold __ Pour Off
Urine: __ Cup __ Tube Swab: __ Red (Bacterial) __ Green (Viral)

24° Urine Volume _____ml Time Collection Started:_____ Ended:_____
Key: CSF = Cerebral Spinal Fluid P = Purple U = Urine G = Gold LTG = Light Green
(FR) = FROZEN (RT) = ROOM TEMPERATURE **ALL OTHER SPECIMENS REFRIGERATED**

NRL/REG # Reg by

DIAGNOSIS / SIGN / SYMPTOM / ICD 9 CODES: All requested laboratory tests must have documented medical necessity. Please provide ICD 9 CODES for highest digit for diagnosis, signs, symptoms for medical necessity in the numbered spaces.

Bill to:
☐ Aetna PPO, POS, OpenAccess, EPO, NAP, MC
☐ Alliance Blue Cross
☐ Alliance Choice Blue Cross
☐ Cigna PPO
☐ First Health PPO
☐ Healthcare USA MC+
☐ Healthlink PPO
☐ Health Link BJC Employees Gold, Silver, Bronze
☐ Hospital/Clinic
☐ IDPA
☐ Medicaid
☐ Medicare
☐ Mercy-Commercial
☐ Patient
☐ Physician's Office
☐ United Health Care
☐ Other _____
(PLEASE ATTACH COPY OF INSURANCE CARD)

Medicare # ☐ Primary ☐ Secondary | Suffix
Medicaid # | State
Ins. Address | Group # | Cert. #
Insured Name | Employer (Name or Number)
Insured SS# (If not patient) – – | Worker's Comp ☐ Yes ☐ No
Secondary Insurance Plan

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

NOTE TO PHYSICIAN: When ordering tests for a Medicare or Medicaid patient, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. Components of the organ or disease panels/combinations printed below are shown and may also be ordered individually below. Components may be billed separately if allowed by the payor.

#	PANELS		
	ORGAN DISEASE PANELS (See Reverse for Components)		
	Basic Metabolic Panel	80048	LTG
	Comprehensive Metabolic Panel	80053	LTG
	Electrolytes Panel	80051	LTG
	Hepatic Function Panel (Liver Profile)	80076	LTG
	Lipid Panel (HDL, Cholesterol & Trig)*	80061	LTG
	Renal Function Panel	80069	LTG
	Acute Hepatitis Panel	80074	LTG
	Obstetric Panel	80055	LTG, 2G, 2P
	INDIVIDUAL TESTS		
	Albumin	82040	LTG
	Alkaline Phosphatase	84075	LTG
	Amylase	82150	LTG
	Anti-Nuclear Antibody, Qual.	86038	(See Manual) G
	Reflex ANA Titer	86039	
	BHCG, Serum Qual.	84703	(See Manual) G
	Reflex BHCG Quant.	84702	G
	BHCG, Urine Qual.	81025	U
	Bilirubin, Direct	82248	LTG
	Bilirubin, Total	82247	LTG
	BUN (Urea Nitrogen)	84520	LTG
	CA 19-9*	86301	RED (FR-Serum)
	CA 15-3*	86300	LTG
	CA 125*	86304	LTG
	C-Reactive Protein	86140	LTG or CSF
	Calcium	82310	LTG
	Carbon Dioxide (Bicarbonate)	82374	LTG
	CBC w/PLT w/auto Differential*	85025	(See Manual) P
	CBC w/PLT w/o auto Differential*	85027	P
	CEA	82378	G
	Chloride	82435	LTG
	Cholesterol*	82465	LTG
	Cortisol	82533	LTG
	Creatine Kinase (CK)	82550	LTG
	Creatinine	82565	LTG
	Digoxin (Lanoxin)*	80162	LTG
	Estradiol	82670	LTG
	Fecal Occult Bld Screen*	G0107	Slide RT
	Fecal Occult Bld Diagnostic*	82270	Slide RT
	Ferritin*	82728	SST
	Folate, Serum	82746	LTG
	Follicle Stim. Hormone (FSH)	83001	LTG
	GGT*	82977	LTG
	Glucose*	82947	LTG

#	INDIVIDUAL TESTS		
	Glycohemoglobin (A1C)*	83036	P
	Hemoglobin	85018	P
	Hematocrit	85014	P
	Hepatitis A Antibody (HAAB), IgM Antibody	86709	LTG
	Hepatitis B Core Antibody (HbcAb), IgM Antibody	86705	LTG
	Hepatitis B Surface Antibody Qual.	86706	LTG
	Hepatitis B Surface Antigen	87340	LTG
	Hepatitis C Virus Antibody	86803	LTG
	Hgb ELP with interp.	83020/83020-26	(See Manual) P
	Reflex Hgb A_2	83020	
	Hgb ELP without interp.	83020	(See Manual) P
	Reflex Hgb A_2	83020	
	HIV 1 & 2 Ab*	86703	(See Manual) RED
	Reflex Western Blot Confirm	86689	
	Immunofixation with Interp.	86334/86334-26	See Manual
	Iron, Total*	83540	LTG
	Iron, Total & Transferrin	83540/84466	LTG
	Lactic Dehydrogenase (LD)	83615	LTG or CSF
	Lead, Blood	83655	See Manual
	LDL (Direct)	83721	LTG
	Lithium (Eskolith)	80178	G
	Luteinizing Hormone (LH)	83002	LTG
	Magnesium	83735	LTG
	Partial Thrombo. Time (PTT)*	85730	Light Blue
	Phenytoin (Dilantin)*	80185	LTG
	Phosphorus	84100	LTG
	Potassium	84132	LTG
	Prolactin	84146	LTG
	Prostate Specific Antigen PSA Diagnostic*	84153	G
	Prostate Specific Antigen PSA Screen	G0103	G
	Last date of PSA _____		
	Protein ELP with Interp.	84165/84165-26	G
	Protein ELP without Interp.	84165	G
	Protein, Total	84155	LTG
	Protime with INR*	85610	Light Blue
	Rheumatoid Factor (RA)	86430	G
	RPR *	86592	(See Manual) G
	Reflex MHA-TP Confirm	86593/86781	
	Rubella Screen, Serum Qual.	86762	G
	Sedimentation Rate (Sed. Rate)	85651	P
	SGOT (AST)	84450	LTG
	SGPT (ALT)	84460	LTG
	Sodium	84295	LTG
	T3	84480	LTG

#	INDIVIDUAL TESTS		
	T3 Uptake*	84479	LTG
	T4 (Thyroxine), Serum Quant.*	84436	LTG
	T4 Free	84439	LTG
	Testosterone	84403	LTG
	Triglycerides*	84478	LTG
	Troponin - I*	84484	LTG
	Thyroid Stim. Hormone (TSH)*	84443	LTG
	Uric Acid	84550	LTG
	Urinalysis (Auto & Micro)	81001	U
	Valproic Acid (Depakote)	80164	LTG
	Varicella Zoster Immunity Screen	86787	Red
	MICROBIOLOGY TEST		
	AFB Culture & Smear +	87116/87015/87206	
	Anaerobe Culture +	87075	(RT)
	Blood Culture +	87040	
	Chlamydia, Nuclear Acid, Amplified	87491	
	Chlamydia & GC, Nuclear Acid, Amplified	87491/87591	
	Clostridium Difficile Toxin (C-Diff.)	87324	
	Cryptosporidium Antigen	87328	
	GC, Nuclear Acid, Amplified	87591	
	Genital Culture, Comprehensive +	87070	(RT)
	Genital Strep Culture +	87081	
	Giardia Antigen	87329	
	Gram Stain	87205	
	Herpes Simplex (Viral) Culture +	87252	
	O & P	87177/88313	(RT)
	Respiratory Culture +	87070	(RT)
	Staph Screen (MRSA) +	87081	(RT)
	Stool Culture +	87045/87046	(RT)
	Throat Strept Culture +	87081	(RT)
	Urinalysis with Culture Reflex +	81001/87086	
	Urine Culture, Catheter* +	87086	
	Urine Culture, Clean Voided* +	87086	
	Viral Culture, Comprehensive	87252/(87254x2)	
	VRE Screen +	87081	(RT)
	Wound Culture +	87070	(RT)
	ADDITIONAL TESTS AND PANELS:		

Specimen & Source _____ ***
*** Indicate Exact Microbiology Specimen Source.
+ = ID and/or Susceptibility is Additional Charge.
* = Red color coded tests are either NCD or LMRP.

CH 384 (08/05/05)

The Codes and Panel structuring are based on our current understanding of ICD9, and CPT rules in effect at the time this order form was printed and may change without notice.

NETWORK COPY

NetworkReferenceLab **Histology Request Form**

SEND REPORT TO

NetworkReferenceLab
11133 Dunn Road
St. Louis, Missouri 63136
(314) 653-4455

Patient Information: (I.D.#)

PLEASE PRINT

Patient's Last Name | First Name | MI

Birthdate / / | Age | Sex | SS# – –

Address

Patient's Phone # ( ) | PCP | Room #

Name of Responsible Party (If Different From Patient) Last Name | MI

Address of Responsible Party

Patient's Relationship To Responsible Party ☐ 1-Self ☐ 2-Spouse ☐ 3-Child ☐ 4-Other

Ordering Physician (If other than PCP)

Bill to:
☐ Aetna PPO, POS, OpenAccess, EPO, NAP, MC
☐ Alliance Blue Cross
☐ Alliance Choice Blue Cross
☐ Cigna PPO
☐ First Health PPO
☐ Healthcare USA MC+
(PLEASE ATTACH COPY OF INSURANCE CARD)
☐ Healthlink PPO
☐ Health Link BJC Employees Gold, Silver, Bronze
☐ Hospital/Clinic
☐ IDPA
☐ Medicaid
☐ Medicare
☐ Mercy-Commercial
☐ Patient
☐ Physician's Office
☐ United Health Care
☐ Other _____

Medicare # ☐ Primary ☐ Secondary | Suffix

Medicaid # | State

Ins. Address | Group # | Cert. #

Insured Name | Employer (Name or Number)

Insured SS# (If not patient) | Worker's Comp ☐ Yes ☐ No

Secondary Insurance Plan

PRESS HARD–3 COPIES
HISTOLOGY

LAB USE ONLY E S

LAB ASSESSION #

ORDERING PHYSICIAN SIGNATURE X: _____

OTHER PHYSICIAN CC: _____

DATE OF SERVICE: _____ / _____ / _____

CLINICAL DATA:

HISTORY: PRE-OPERATIVE DX:

OPERATIVE PROCEDURE:

OPERATIVE FINDINGS / DX:

SPECIMEN(S)

IF CONSULTATION / SPECIAL HISTOLOGY: CLIENT ACCESSION #: _____ # BLOCKS: _____ # SLIDES: _____

TISSUE(S) REMOVED # OF CONTAINERS SENT: _____ **(Each container must be properly labeled)**

PATHOLOGY USE ONLY BELOW LINE

INTRAOPERATIVE DX:

COMMENTS:

NetworkReferenceLab **Chain-of-Custody Test Request**

NetworkReferenceLab
11133 Dunn Road
St. Louis, Missouri 63136
(314) 653-4455
1-800-533-7720

SEND REPORT TO

Patient Information

Patient's Last Name | First Name | Initial

Birthdate | Age | Sex | SS#

CHAIN OF CUSTODY TEST REQUEST

ANALYTICAL INFORMATION Please check appropriate box

- ☐ Drug of Abuse Screen I
- ☐ Drug of Abuse Screen II
- ☐ Drug of Abuse Screen I with Automatic GC/MS
- ☐ Drug of Abuse Screen II with Automatic GC/MS
- ☐ Drug of Abuse Screen IV with Automatic GC/MS
- ☐ Blood Alcohol
- ☐ Other _____

COLLECTION INFORMATION

Collection Facility
Collection Location
Phone
Specimen Type ☐ Urine ☐ Blood ☐ Both
Collection Date
Collection Time _____ AM PM

TO BE COMPLETED BY COLLECTOR

☐ Pre-employment ☐ Post-Accident ☐ Random ☐ Periodic Medical ☐ Reasonable Suspicion / For Cause ☐ Other (Specify) _____

READ SPECIMEN TEMPERATURE WITHIN FOUR MINUTES OF COLLECTION. Check the box below if reading is within the specified range,

☐ 90.5 - 99.8 F / 32.5 - 37.7 C or record actual temperature here _____

CONSENT FORM

I grant permission for blood and/or urine specimens to be taken and tested for determining the presence of alcohol, and/or controlled substances and other intoxicants. I hereby give permission to Network Reference Lab to release the results of these tests to the Collection Agency. In the case of screening for employment or pre-employment, I also authorize Network Reference Lab to release the results of these tests to my employer or prospective employer and/or their authorized health care professionals.

I hereby release and discharge Christian Hospital Northeast-Northwest, its affiliated entities, their agents and employees from all responsibility for any adverse consequences that may result from the urine/blood test results and/or effects from the taking of the urine/blood sample.

If taking medication, please list names of all drugs or medications:

_____
_____
_____

Signature _____ Date _____ Time _____ AM PM

Witness _____ Date _____ Time _____ AM PM

DATE	CHAIN OF CUSTODY		PURPOSE
	SUBJECT	Collector's Printed Name Collector's Signature	**To Provide the Specimen for Shipping Preparation**
	Collector's Printed Name Collector's Signature	**COURIER**	**For Transport To Network Reference Lab**
	Network Reference Lab Use Only **COURIER**	Printed Name (Network Reference Lab Use Only) Signature (Network Reference Lab Use Only)	**Log In**
	Printed Name (Network Reference Lab Use Only) Signature (Network Reference Lab Use Only)	**Internal Chain of Custody Form**	**Transfer**

Christian Hospital Hematopathology-Bone Marrow Requisition

Christian Hospital
BJC HealthCare℠

HEMATOPATHOLOGY / BONE MARROW REQUISITION

ADDRESSOGRAPH

Date / Time Collected	☐ In Patient ☐ Out Patient	Ordering Physician:	Send additional Copies To:

Clinical History / Physical Findings / Pertinent Therapy / Medications

Specimen Type	Test Requested
☐ Peripheral Blood	☐ Bone Marrow Interpretation (smears / touch imprints / core biopsy)*
☐ Bone Marrow (Specify site) _____ _____ _____	☐ Flow Cytometric Immunophenotyping (Yellow, Green or Purple top tubes acceptable) ☐ Cytogenetic Analysis (Green top tube) ☐ Addition Requests (Cultures, FISH **PCR***): _____ _____ _____
☐ Other (Specify site) _____ _____ _____	* *Please send peripheral blood sample if none recently drawn, as it will be examined concurrently with marrow.* ***Green top tube for FISH* **** Purple top tube preferred*

For Lab Use Only: Materials Received

Physician's Signature: **Date:**

DO NOT WRITE BELOW THIS LINE

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.

Bordetella **Examination Request**

BORDETELLA EXAMINATION REQUEST

1. **Please provide the patient information requested.**
2. **Type or print with pressure.**
3. **Send all copies of this form with specimen to laboratory.**

PATIENT NAME (LAST, FIRST) **PLEASE PRINT**

ADDRESS (STREET, CITY, STATE, ZIP CODE)

BIRTHDATE

SEX ☐ Female ☐ Male

RACE WH | B | HISP | AI/AN | ASIA | OTHER

MEDICAID NUMBER

The following information MUST BE PROVIDED in order to receive results:

PERSON'S NAME AUTHORIZED TO RECEIVE PHONE RESULTS

FACILITY/LAB PHONE NO.

FACILITY/LABORATORY NAME

FACILITY/LABORATORY STREET/MAILING ADDRESS

FACILITY/LABORATORY CITY, STATE & ZIP CODE

DATE SPECIMEN COLLECTED

ONSET DATE

SOURCE OF SPECIMEN

IMMUNIZATIONS/TYPE AND DATES

TREATMENT/TYPE AND DATES

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
STATE PUBLIC HEALTH LABORATORY
101 N. CHESTNUT, PO BOX 570
JEFFERSON CITY MO 65101

EOAA EMPLOYER
Services Provided on a Non-Discriminatory Basis

STATE LAB SERIAL NO.

FOR STATE HEALTH LAB USE ONLY

DATE REPORTED

LABORATORY REPORT

TEST PERFORMED	NOT FOUND	FOUND
BORDETELLA PCR (SEE DISCLAIMER)		
BORDETELLA CULTURE		

FOR STATE HEALTH LAB USE ONLY

PCR DISCLAIMER

The PCR results on this report were obtained with research procedures, thus the testing is not regulated under CLIA '88. Be advised that the target sequence IS481 used in this procedure for *Bordetella pertussis* may also be present in certain strains of *B. holmesii* and *B. bronchiseptica.*

MO 580-1589 (5-07)

LAB-26

NetworkReferenceLab **Allergen Test Request Form**

NetworkReferenceLab
11133 Dunn Road
St. Louis, Missouri 63136

Phone: (314) 653-4455
1-800-533-7720
Fax: (314) 653-4156

Patient Information: (I.D.#)

PLEASE PRINT

Patient's Last Name | First Name | MI

Birthdate / / | Age | Sex | SS#

Address | PCP

City | State | Zip Code | Patient's Phone # ( )

Name of Responsible Party (If Different From Patient) Last Name | MI

Address of Responsible Party

Patient's Relationship To Responsible Party ☐ 1-Self ☐ 2-Spouse ☐ 3-Child ☐ 4-Other

Ordering Physician (If other than PCP)

Bill to: ☐ PATIENT ☐ INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ CLIENT ☐ OTHER _____

(PLEASE ATTACH COPY OF INSURANCE CARD)

Medicare # ☐ Primary ☐ Secondary | Suffix

Medicaid # | State

Ins. Address | Group # | Cert. #

Insured Name | Employer (Name or Number)

Insured SS# (If not patient) | Worker's Comp ☐ Yes ☐ No

Secondary Insurance Plan

Physician's Signature _____

Nurse's Signature _____ Beeper # _____

☐ STAT Assay ☐ Fax Results/No. _____

☐ Phone Results To: ☐ Exch. _____ Office _____

☐ Send Additional Copies To: _____

Collection Date:___/___/___ Time:_____ Fasting: ☐ Yes _____hrs. ☐ No

Location of Draw: ☐ NE ☐ NEPOB1 ☐ NEPOB2 ☐ NWHC ☐ GMC ☐ Other Initials_____

Tubes: ___ Purple ___ Lt Green ___ Red ___ Blue ___ Gold ___ Pour Off

Urine: ___ Cup ___ Tube Swab: ___ Red (Bacterial) ___ Viral Transport

NRL/REG #_____ Reg by_____

DIAGNOSIS / SIGN / SYMPTOM / ICD 9 CODES: All requested laboratory tests must have documented medical necessity. Please provide ICD 9 CODES for highest digit for diagnosis, signs, symptoms for medical necessity in the numbered spaces.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

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.

ROUTINE ALLERGEN PROFILES 0.1 mL SERUM PER ALLERGEN

☐ **MO/ILL REGIONAL SCREEN 14 TESTS**
Dermatoph. Pteronyssinus
Dermatoph farinae
House Dust - Hollister Stier
Cat Dander
Dog Dander
Bermuda Grass
Rye Grass
Timothy
Cladosporium herbarium
Alternaria tenuis
Maple (Box Elder)
Oak
Elm
Ragweed

☐ **MUSSEL/SHELLFISH PANEL - 4 TESTS**
Blue Mussel
Crab
Lobster
Shrimp

☐ **HYMENOPTERA PANEL - 6 TESTS**
Fire Ant
Honey Bee
Paper Wasp
White Face Hornet
Yellow Face Hornet
Yellow Jacket

☐ **EXPANDED FOOD ALLERGY PROFILE - 12 ALLERGENS + TOTAL IgE**
f207 Clam
f3 Cod fish
f8 Corn
f1 Egg white
f2 Milk
f13 Peanut
f338 Scallop
f10 Sesame
f24 Shrimp
f14 Soybean
f256 Walnut
f4 Wheat
Total IgE

☐ **EXPANDED RESPIRATORY ALLERGY PROFILE - REGION 8 - 25 ALLERGENS + TOTAL IgE**
(Ages: 2 years and up)
d1 Dust Mite: *D. pteronyssinus*
d2 Dust Mite: *D. farinae*
e1 Cat dander
e5 Dog dander
i6 Cockroach
m2 Mold: *Cladosporium herbarium*
m3 Mold: *Aspergillus Fumigatus*
m6 Mold: *Alternaria alternata*
m1 Mold: *Penicillium notatum*
t1 Maple
t6 Mountain Cedar
t7 Oak
t8 Elm
t11 Sycamore
t14 Cottonwood
t15 White Ash
t10 Walnut Tree
t22 Pecan/Hickory Tree
t70 Mulberry
g2 Bermuda grass
g6 Timothy grass
w1 Common ragweed
w11 Russian Thistle
w14 Rough pigweed
w16 Rough marshelder
Total IgE

☐ **EXPANDED CHILDHOOD ALLERGY PROFILE - 15 ALLERGENS + TOTAL IgE**
(Ages: 3 months - 2 years)
f3 Cod fish
f1 Egg white
f2 Milk
f13 Peanut
f24 Shrimp
f14 Soybean
f256 Walnut
f4 Wheat

d1 Dust Mite: *D. pteronyssinus*
d2 Dust Mite: *D. farinae*
e1 Cat dander
e5 Dog dander
i6 Cockroach
m2 Mold: *Cladosporium herbarium*
m6 Mold: *Alternaria alternata*

Total IgE

☐ **RESPIRATORY ALLERGY PROFILE (INFANT)- 6 TESTS**
(Ages: 3 months - 2 years)
Dermatophagoides farinae
Dermatophagoides pteronyssinus
Cat dander
Dog dander
Cockroach
Alternaria tenuis

INDIVIDUAL ALLERGEN 0.1 mL SERUM PER ALLERGEN

FOOD

☐ f20 Almond
☐ f76 Alpha-lactalbumin
☐ f49 Apple
☐ f96 Avocado
☐ f45 Baker's yeast
☐ f92 Banana
☐ f6 Barley
☐ f27 Beef
☐ f256 Black walnut
☐ f77 b-Lactoglobin
☐ f37 Blue mussel
☐ Rf288 Blueberry
☐ f18 Brazil nut
☐ f11 Buckwheat
☐ f93 Cacao (Cocoa)
☐ f31 Carrot
☐ f78 Casein
☐ f202 Cashew
☐ f85 Celery
☐ f81 Cheese, CHEDDAR type
☐ f82 Cheese, MOLD type
☐ f83 Chicken meat
☐ f207 Clam
☐ f36 Coconut
☐ f3 Codfish
☐ f23 Crab
☐ f1 Egg White
☐ f75 Egg Yolk
☐ f47 Garlic
☐ f79 Gluten
☐ Rf315 Green bean
☐ Rf303 Halibut
☐ f17 Hazel nut
☐ f84 Kiwi fruit
☐ f80 Lobster
☐ Rf345 Macadamia nut
☐ f8 Maize (corn)
☐ f91 Mango
☐ f87 Melons
☐ f2 Milk
☐ f89 Mustard
☐ f88 Mutton
☐ f7 Oat
☐ f33 Orange
☐ f290 Oyster
☐ f86 Parsley
☐ f12 Pea
☐ f13 Peanut
☐ f201 Pecan
☐ Rf253 Pine nut, pignoles
☐ f203 Pistachio
☐ f26 Pork
☐ f35 Potato
☐ Rf343 Raspberry
☐ f9 Rice
☐ F5 Rye
☐ f41 Salmon
☐ f10 Sesame Seed
☐ f24 Shrimp
☐ f14 Soybean
☐ f44 Strawberry
☐ k84 Sunflower seed
☐ f25 Tomato
☐ f204 Trout
☐ f40 Tuna
☐ f284 Turkey
☐ f4 Wheat
☐ f15 White Beans

SPECIALIZED/ ADDITIONAL ALLERGENS