

LAB REQUEST FORM

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LABEL – LAB ONLY

PRACTICE INFORMATION

Facility/Clinic Name: _____ **Ordering Physician:** _____ **NPI#** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

PATIENT INFORMATION: Please attached medication list & patient demographic sheet or complete the following section.

First Name: _____ **Last Name:** _____ **DOB:(MM/DD/YYYY)** _____ **Sex: __F __M**
Phone Number: _____ **Address:** _____ **City/State/Zip:** _____

SPECIMEN INFORMATION: **Date Collected :** ____/____/____ **Time:** ____:____ am pm **Fasting:** __ Yes __ No

BILLING INFORMATION: Please attached patient demographic sheet & copy of insurance card __ Medicare __ Commercial __ Self-Pay

PANELS AND PROFILES:

- | | | |
|--|---|---|
| <input type="checkbox"/> Basic Metabolic Panel SST | <input type="checkbox"/> Comprehensive Metabolic Panel (CMP) SST | <input type="checkbox"/> Lipid Profile SST |
| <input type="checkbox"/> RenalPanel SST | <input type="checkbox"/> Electrolytes Panel SST | <input type="checkbox"/> Thyroid Panel SST |
| <input type="checkbox"/> Complete Blood Count (CBC) LAV | <input type="checkbox"/> Hepatic Function Panel SST | |

INDIVIDUAL TESTS

CHEMISTRY:

- | | |
|---|--|
| <input type="checkbox"/> Albumin BCP SST <input type="checkbox"/> Alkaline Phosphatase SST <input type="checkbox"/> ALT SST <input type="checkbox"/> Amylase SST <input type="checkbox"/> Anti-Tg SST <input type="checkbox"/> Anti-TPO SST <input type="checkbox"/> Apolipoprotein B SST <input type="checkbox"/> AST SST <input type="checkbox"/> B-12 & Folate SST <input type="checkbox"/> Bilirubin (Direct) SST <input type="checkbox"/> Bilirubin (Total) SST <input type="checkbox"/> BUN (Urea Nitrogen) SST <input type="checkbox"/> Kt/V and URR SST <input type="checkbox"/> Calcium SST <input type="checkbox"/> Carbon Dioxide SST <input type="checkbox"/> Chloride SST <input type="checkbox"/> Cholesterol, Total SST <input type="checkbox"/> CK, Total(Creatinine Kinase) SST <input type="checkbox"/> C-peptide, serum SST <input type="checkbox"/> CRP (C-reactive Protein) SST <input type="checkbox"/> Direct LDL (DLDL) SST <input type="checkbox"/> Ferritin SST <input type="checkbox"/> Folate SST <input type="checkbox"/> Glucose SST <input type="checkbox"/> HCG, Quant SST <input type="checkbox"/> Hemoglobin A1c SST <input type="checkbox"/> Hep A antibody, IgM SST <input type="checkbox"/> Hep B surface antibody SST <input type="checkbox"/> Hep A surface antigen SST <input type="checkbox"/> Hep C antibody SST <input type="checkbox"/> Hep C VIRUS, QUAN,PCR SST <input type="checkbox"/> HDL (Ultra) SST <input type="checkbox"/> HIV ½ Antibodies SST <input type="checkbox"/> Homocysteine SST | <input type="checkbox"/> Insulin SST <input type="checkbox"/> Iron SST <input type="checkbox"/> TIBC (Total Iron Binding Capacity) SST <input type="checkbox"/> LDH (Lactate Dehydrogenase) SST <input type="checkbox"/> Lipoprotein (a) SST <input type="checkbox"/> Lithium SST <input type="checkbox"/> Magnesium SST <input type="checkbox"/> Phosphorus SST <input type="checkbox"/> Potassium SST <input type="checkbox"/> Prealbumin SST <input type="checkbox"/> Total Protein SST <input type="checkbox"/> PTH (Parathyroid Hormone) LAV <input type="checkbox"/> Rheumatoid Factor (RF) SST <input type="checkbox"/> Sodium SST <input type="checkbox"/> T3-Uptake SST <input type="checkbox"/> T3-Free SST <input type="checkbox"/> T3-Total SST <input type="checkbox"/> T4-Total SST <input type="checkbox"/> T4-Free SST <input type="checkbox"/> Testosterone Free SST <input type="checkbox"/> Testosterone Total SST <input type="checkbox"/> Triglycerides SST <input type="checkbox"/> TSH SST <input type="checkbox"/> Uric Acid SST <input type="checkbox"/> Valproic Acid SST <input type="checkbox"/> Vitamin B12 SST <input type="checkbox"/> Vitamin D SST |
|---|--|
- Additional tests:**

COAGULATION:

- | | |
|--|--|
| <input type="checkbox"/> PT BLU | <input type="checkbox"/> INR BLU |
| <input type="checkbox"/> TT BLU | <input type="checkbox"/> Platelet Count LAV |

HORMONES:

- | | |
|--|--|
| <input type="checkbox"/> Testosterone, Free & Total w/ SHBG SST | <input type="checkbox"/> IGF-1 SST |
| <input type="checkbox"/> Estradiol (E2) SST | <input type="checkbox"/> Progesterone SST |
| <input type="checkbox"/> dhea-sulfate SST | <input type="checkbox"/> Cortisol SST |
| <input type="checkbox"/> Prolactin SST | |

PANELS:

- | | |
|---|--|
| <input type="checkbox"/> 2781 - Female Hormone A Panel Requires – 1 SST Testosterone, Free & Total w/SHBG Estradiol (E2) DHEA-Sulfate Cortisol Progesterone | <input type="checkbox"/> 2780 - Male Hormone A Panel Requires – 1 SST Testosterone, Free & Total w/SHBG Estradiol (E2) DHEA-Sulfate Cortisol |
| <input type="checkbox"/> 907B - Female Wellness Panel Requires – 1 SST, 1 LAV CBC, CMP, LIPID Panel T3, Total, T4, Total, Vitamin D, Total | <input type="checkbox"/> 908B -Male Wellness Panel Requires – 1 SST, 1 LAV CBC, CMP, Lipid Panel, TSH, T3, Total, T4 Total, PSA, Testosterone Free & Total w/ SHBG |

Diagnosis codes:

- | | |
|---|---|
| <input type="checkbox"/> Fatigue R53.83 <input type="checkbox"/> Fever R50.9 <input type="checkbox"/> Gout, unspec. M10.9 <input type="checkbox"/> Hypertension I10 <input type="checkbox"/> Hyperlipidemia, unspec E78.5 <input type="checkbox"/> Diabetes II, controlled E11.9 <input type="checkbox"/> Iron Deficiency D50.9 Other: _____ | <input type="checkbox"/> Diabetes II, uncontrolled E11.65 <input type="checkbox"/> Iron Deficiency D50.9 <input type="checkbox"/> Routine/Annual Health Z00.00 <input type="checkbox"/> Nausea with vomiting R11.2 <input type="checkbox"/> Shortness of breath R06.02 <input type="checkbox"/> Gerd/Reflux K21.9 <input type="checkbox"/> Vitamin D Deficiencies E55.9 |
|---|---|

Ordering Physician (Print) _____

Signature _____

Date _____

I attest that the requested testing is medically necessary and appropriate based on the patient's diagnosis and treatment plan. I have personally completed the diagnosis codes above to indicate the accurate diagnosis for this patient.