

Please refer to BVHS Laboratory Test Catalog at www.bvhealthsystem.testcatalog.org
This form is for laboratory testing only. Do not use this form for any other purposes.

LAB PHONE: 419-423-5318
LAB FAX: 419-423-5362

LAB PHONE: 419- 369- 2314
LAB FAX: 419-358-2639

LABORATORY SERVICES OUTPATIENT SPECIMEN FORM

* = Required

<input type="checkbox"/> DATE OF TESTING: _____ <input type="checkbox"/> Date Range of Testing: Beginning Date: _____ End Date: _____ <input type="checkbox"/> Standing / Recurring Order: Frequency: _____ Expires: _____	ORDERING PROVIDER: Please Print Legibly Name: _____ NPI#: _____	Special Request Distribution (answer only if medical practice has NOT previously been set up for result distribution with BVHS or a special circumstance) <input type="checkbox"/> Call Results to: _____ <input type="checkbox"/> Fax Results to: _____ <input type="checkbox"/> Copy Results to: _____
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Patient Information (PRINT LEGIBLY)

 (Patient Last Name)* (maiden if recently changed) (Patient First Name)* (Patient Middle Name) Date of Birth* ____/____/____
 Birth Sex* Male Female

SSN* ____/____/____ Address: _____

Phone #: _____

SUPPORTING DIAGNOSIS*:

<input type="checkbox"/> Complete Blood Count w/ Differential <input type="checkbox"/> Complete Blood Count w/out Diff <input type="checkbox"/> Erythrocyte Sedimentation Rate (ESR) <input type="checkbox"/> Prothrombin Time (INR) <input type="checkbox"/> Basic Metabolic Panel (Sodium, Potassium, Chloride, Carbon Dioxide, Glucose, BUN, Creatinine, Calcium) <input type="checkbox"/> Comprehensive Metabolic Panel (Sodium, Potassium, Chloride, Carbon Dioxide, Anion GAP, Glucose, BUN, Creatinine, Total Bilirubin, Alk, Phos., AST, ALT, Total Protein, Albumin, Calcium) <input type="checkbox"/> Electrolyte Panel (Sodium, Potassium, Chloride, Carbon Dioxide) <input type="checkbox"/> Lipid Panel (Triglycerides, Total Cholesterol, HDL, LDL, Cardiac Risk Factor) <input type="checkbox"/> Hepatic Function Panel (Total Bilirubin, Direct Bilirubin, Indirect Bilirubin, Alkaline Phosphatase, AST, ALT, Total Protein, Albumin) <input type="checkbox"/> Renal Panel (Sodium, Potassium, Chloride, Carbon Dioxide, Glucose, BUN, Creatinine, Albumin, Phosphorus, Calcium) <input type="checkbox"/> Vitamin D (25-Hydrox) – (D2 & D3 combined) <input type="checkbox"/> TIBC (Iron, Transferrin, Total Iron Binding Capacity, Iron Saturation) <input type="checkbox"/> B12 & Folate <input type="checkbox"/> TSH <input type="checkbox"/> TSH w/ Reflex Free T4 <input type="checkbox"/> Total T3 <input type="checkbox"/> Free T3 <input type="checkbox"/> Total T4 (Thyroxine) <input type="checkbox"/> Free T4 <input type="checkbox"/> Total PSA (Screening) <input type="checkbox"/> Total PSA (Diagnostic) <input type="checkbox"/> PSA Profile (Free & Total PSA) (Diagnostic) <input type="checkbox"/> Additional/Misc. Orders:	<input type="checkbox"/> ANA Screen <input type="checkbox"/> Mono Test <input type="checkbox"/> High Sensitivity CRP <input type="checkbox"/> Rheumatoid Factor (RF) <input type="checkbox"/> Hemoglobin A1c <input type="checkbox"/> Glucose <input type="checkbox"/> Insulin <input type="checkbox"/> Magnesium <input type="checkbox"/> Uric Acid <input type="checkbox"/> Phosphorus <input type="checkbox"/> Urine Pregnancy Test <input type="checkbox"/> Serum Pregnancy Test <input type="checkbox"/> Beta-HCG (Quantitative) <input type="checkbox"/> Treponema (Syphilis) Total Antibody <input type="checkbox"/> Bilirubin, Total <input type="checkbox"/> Drug Level _____ Last Dose Time: _____ <input type="checkbox"/> Hepatitis Profile, Acute (HAV IgM, HBsAg, HBe IgM, HCV) <input type="checkbox"/> Hepatitis B Profile (HBsAb, HBsAg, HBe IgM) <input type="checkbox"/> Blood Type & Rh <input type="checkbox"/> Blood Type & Antibody Screen	PCR Molecular See Swab Reference Guide for proper collection Container(s) and storage requirements. <input type="checkbox"/> Source: _____ (required) <input type="checkbox"/> Vaginal DNA Panel <input type="checkbox"/> Influenza A/B <input type="checkbox"/> RSV <input type="checkbox"/> GC/CHLA <input type="checkbox"/> SARS-CoVID <input type="checkbox"/> Group B Strep <input type="checkbox"/> SARS-CoVID/FLU/RSV+ (Quad) <input type="checkbox"/> MRSA <input type="checkbox"/> Respiratory Pathogens Panel Microbiology - Cultures & Sensitivity <input type="checkbox"/> Source: _____ (required) <input type="checkbox"/> Aerobic <input type="checkbox"/> Anaerobic <input type="checkbox"/> Fungal <input type="checkbox"/> Acid Fast <input type="checkbox"/> Blood Cultures (sets) x _____ URINE for: <input type="checkbox"/> Routine Urinalysis ONLY (No Culture) <input type="checkbox"/> Urinalysis w/ Reflex Culture & Sensitivity if indicated <input type="checkbox"/> Urinalysis AND Culture & Sensitivity <input type="checkbox"/> Urine for Culture ONLY (No Urinalysis) <input type="checkbox"/> Albumin/Creatinine Ratio, Random Urine <input type="checkbox"/> Protein / Creatinine Ratio, Random Urine Stool Studies: See Stool Collection Instructions for proper collection container(s) and storage requirements <input type="checkbox"/> H. pylori Antigen <input type="checkbox"/> Fecal Lactoferrin (WBC) <input type="checkbox"/> Occult Blood <input type="checkbox"/> Calprotectin <input type="checkbox"/> Clostridium Difficile (C.diff) <input type="checkbox"/> Elastase-1 <input type="checkbox"/> Ova & Parasite Exam (includes Giardia Crypto Antigen) <input type="checkbox"/> Enteric Pathogens DNA Panel by PCR (previously Stool Culture) (Campylobacter Group, Salmonella species, Shigella species, Vibrio Group, Yersinia enterocolitica, Norovirus GI/GII, Rotavirus A, Shiga toxin 1 & 2)
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***Date/Time:** _____

***Provider Signature:** _____

Signature Stamp NOT Permitted