

Instructions for properly filling Out Lab requisitions

Providing a completely filled out lab Requisition is critically important for patient safety, and compliance. The following instructions insures a valid lab order is submitted to our laboratory. It is the policy of St. Charles Health System to not allow any physician or other licensed independent providers to prescribe for themselves or their family members. This includes ordering of tests, which are considered the practice of medicine and are not to be provided to oneself or a member of one's family.

1. **Patient Information** full legal name (as shown on their legal photo ID), Date of birth and Gender
2. **Specimen information:** requested and collection dates & times, Standing order, STAT, Fasting or Non-Fasting, and priority reporting for Calling or faxing results. Only fax numbers out of public view should be provided.
3. **Billing:**
 - Patient/Insurance - fill out completely or write see attachment when providing "patient details sheets" including billing information. We prefer copies of photo ID, copies of insurance cards front and back.
 - Bill Clinic - billing to clinic directly, write "Bill Clinic".
4. **Cures Act** -Select blocking reason when appropriate. This will block immediate release of results to patients.
5. **Provider signature** on a requisition is encourageage, if requisition is not signed, for compliance to support testing/billing there must be documentation in the clinics/providers patient chart to support lab testing was indicated.
6. **Physician notice:** Review this notice. Indicate a valid ICD Code(s) supported in the patient chart to document medical necessity, if ICD does not support medical necessity, explain and obtain ABN with patient signature to accompany this requisition. If
7. **Indicate Source and Site** for every culture, for urines indicate clean catch or voided.
8. **Medicare screening test(s)** require an ABN for medicare, for frequency issue. And helpful ICD codes when only a specific ICD is allowed.
9. **Mark testing or write in test(s)** if not on the preprinted requisition.

St. Charles Health System Laboratory Services
BEND • REDMOND • MADRAS • PRINEVILLE • LAPINE
Laboratory Hours and Locations: 541-706-7717 • stcharleshealthcare.org / Laborat
Lab Fax: 541-706-6365

REQUESTED DATE: ___/___/___
COLLECTED DATE: ___/___/___
COLLECTED TIME: ___:___:___

1 Patient Last Name, First Name, Middle Name, Address, Birth Date, Sex, Assigned Gender, City, State, Zip, Home Phone, Patient SS#, Assigned Gender.

3 **INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)**
PRIMARY Medicare Medicaid Other
Insurance Name & Address, City, State, Zip, Subscriber or Guarantor Last Name, First, Middle, DOB, Beneficiary / Member #, Group #

4 **Cures Act - Reason for Blocking Immediate Release of Results to Patient:**
 Patient or Proxy Request
 Likely to lead to physical harm of the patient or others
 Likely to be used in a civil, criminal, or administrative action or procedure

5 Phys Signature, For Lab Use Only, Phlebotomist Initials, Time

6 **PHYSICIAN NOTICE** By ordering testing from St. Charles, the ordering provider permits the immediate release of test results to the patient. When ordering tests, the physician is required to make an independent medical necessity decision with regard to each test the laboratory will bill. The physician also understands he or she is required to (1) submit ICD-10 diagnosis supported in the patient's medical record as documentation of the medical necessity or (2) explain and have the patient sign an ABN.

ICD-10 Codes(s) Diagnosis: 1) 2) 3) 4) 5) 6)

7 Profile No CBC (inc LDH w the above)
MICROBIOLOGY (ID & Sens added if indicated)
SOURCE / SITE REQUIRED
 Culture, AFB w / smear
 Culture, Blood
 Culture, Fungus

8 **MEDICARE SCREENING (ABN Required)**
Diabetic Screen - (x) one below
 Fasting Glucose
 Glucose Tolerance Test ___hr (1/2/3)
 Gestational GTT ___hr (1/2/3)
Dx: Z13.1
 Fecal Occult Blood (FOB)
 PSA Screen
Dx: Z12.5
 HIV-1/HIV-2 Ab Screen (w/conf if pos)
 Hep C (HCV) Antibody w/Reflex
STIs Screening (X) below
 Chlamydia / GC DNA probe Trich
 Syphilis Screen (w / confirmation if indicated)
 Hepatitis B Surface Antigen

9 **MISCELLANEOUS TESTS**