Requisition online – Instructions

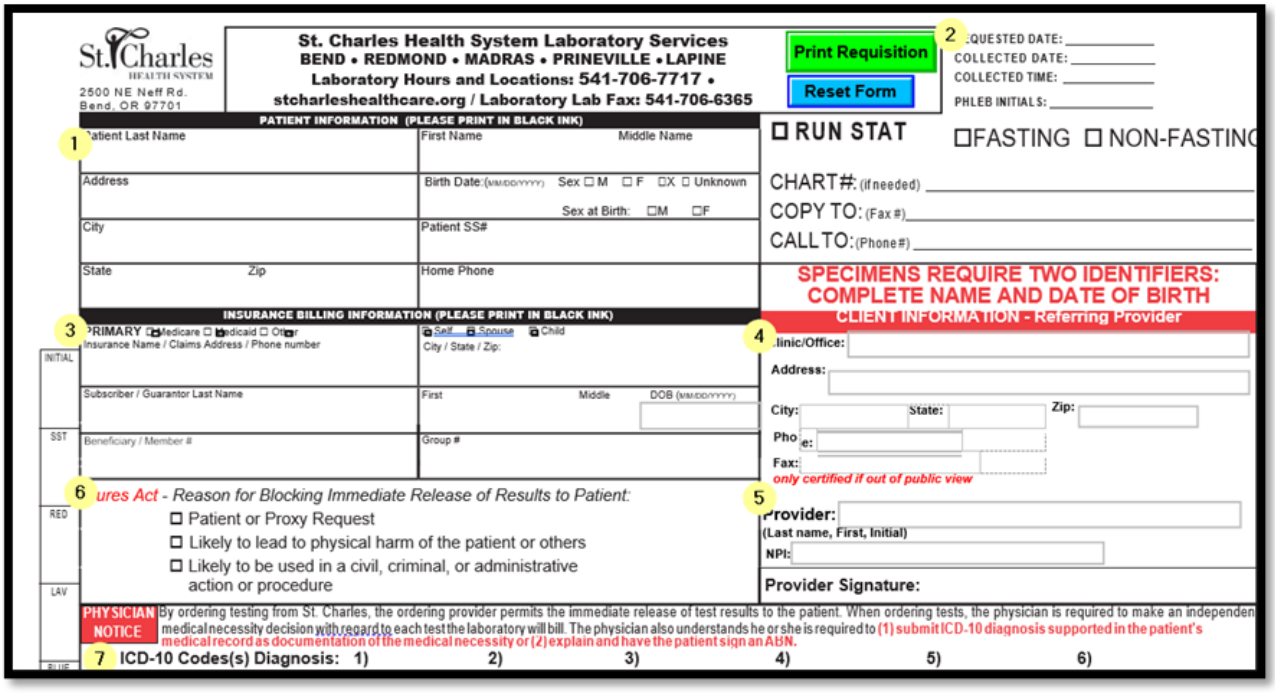
Only use our online requisition if:

- **The Provider/Facility is not already established with pre printed requisitions.**
- **The Provider is Out of Town and is sending a patient to St. Charles Laboratories.**

For patient safety we will reject all handwritten or incomplete online requisition forms

Using the online form completely fill in all required fields on the requisition, **do not** print and hand write the information, this will be rejected. For patient safety, and compliance it is critical to provide all information being requested. The following instructions ensures 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 (include frequency and duration, orders expire 1yr from order date, 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 and submit a "patient details sheet" including billing information. We prefer copies of photo ID, copies of insurance cards front and back.
   - Bill Clinic – We do not direct bill provider owed clinics. Contact lab for more information.
4. **Clinic/Office:** Name of Clinic, address phone and Fax, fax location must be out of public view.
5. **Provider name, NPI and Provider signature** on a requisition is encourage, 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. Cures Act -Select blocking reason when appropriate. This will block immediate release of results to patients.
7. **Physician 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
   NOTE: Codes that start with V,W,X,Y are unacceptable for lab services.
8. **Indicate Source and Site** for every culture, for urines indicate clean catch or voided.
9. **Medicare screening test**(s) require an ABN for Medicare, for frequency issue. And helpful ICD codes when only a specific ICD is allowed.
10. **Mark testing or type in test**(s) under Miscellaneous section on this requisition.


St. Charles HEALTH SYSTEM
2500 NE Neff Rd.
Bend, OR 97701

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

Print Requisition
Reset Form

2 REQUESTED DATE:
COLLECTED DATE:
COLLECTED TIME:
PHLEB INITIALS:

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)
1 Patient Last Name | First Name | Middle Name
Address | Birth Date: (MM/DD/YYYY) Sex ☐ M ☐ F ☐ X ☐ Unknown | Sex at Birth: ☐ M ☐ F
City | Patient SS#
State | Zip | Home Phone

☐ RUN STAT ☐ FASTING ☐ NON-FASTING
CHART#: (if needed)
COPY TO: (Fax #)
CALL TO: (Phone #)

SPECIMENS REQUIRE TWO IDENTIFIERS:
COMPLETE NAME AND DATE OF BIRTH

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)
3 PRIMARY ☐ Medicare ☐ Medicaid ☐ Other
Insurance Name / Claims Address / Phone number | ☐ Self ☐ Spouse ☐ Child | City / State / Zip:
Subscriber / Guarantor Last Name | First | Middle | DOB (MM/DD/YYYY)
Beneficiary / Member # | Group #

CLIENT INFORMATION - Referring Provider
4 Clinic/Office:
Address:
City: State: Zip:
Phone:
Fax:
only certified if out of public view

6 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 Provider: (Last name, First, Initial)
NPI:
Provider Signature:

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.

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

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CHART #: (if needed) _____
COPY TO: (Fax #) _____
CALL TO: (Phone #) _____

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Patient Last Name | First Name | Middle Name
Address | Birth Date:(MM/DD/YYYY) Sex ☐ M ☐ F ☐X ☐ Unknown | Sex at Birth: ☐M ☐F
City | Patient SS#
State | Zip | Home Phone

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)

PRIMARY ☐ Medicare ☐ Medicaid ☐ Other
Insurance Name / Claims Address / Phone number | ☐ Self ☐ Spouse ☐ Child | City / State / Zip:
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ICD-10 Codes(s) Diagnosis: 1) 2) 3) 4) 5) 6)

INITIAL | SST | RED | LAV | BLUE | YELLOW | GREEN | GREY | SERUM | PLASMA | SLIDE | URINE | CULT | EIA | MISC | FZN

HEMATOLOGY / COAG / SEROLOGY / BLD BANK

- ☐ **CBC with Auto Differential**
- ☐ **CBC with Manual Diff**
- ☐ **CBC w/o Diff (Hemogram)**
- ☐ **Platelet Count**
- ☐ Retic Count
- ☐ Sed Rate (ESR)
- ☐ Smear for EOS
- ☐ Fibrinogen
- ☐ **PT / INR** ☐ Coumadin
- ☐ **PTT** ☐ Heparin
- ☐ ANA (w/Titer & Pattern added if indicated)
- ☐ Hepatitis B Surface Ab
- ☐ **Hep C (HCV) Antibody w/Reflex**
- ☐ HCV RNA Quant by PCR
- ☐ HCV RNA Quant w/Reflex to HCV Genotype
- ☐ **HIV-1 / HIV-2 Ab Screen** (w / conf if pos)
- ☐ Mono Test
- ☐ Rheumatoid Factor (RA) Screen (Titer if pos)
- ☐ ABO & RH
- ☐ Antibody Screen (for RHOGAM? ___)
- ☐ Hold for crossmatch (fill out & fax Trans. form)

URINE _ _ RANDOM _ _ 24 Hr

- ☐ Microalbumin, Urine (w creat & ratio)
- ☐ Protein Electroph,Urine ☐ Reflex IFE
- ☐ **Urinalysis Complete w microscopic**
- ☐ **Urinalysis with Culture if indicated**
- ☐ **Urinalysis Microscopic Only**
- ☐ **Urinalysis Dip w/o microscopic**

UA SOURCE: ☐Cath ☐CC ☐Voided

FLUID ANALYSIS

- ☐ Cell Count & Diff, Fluid _____ Source
- ☐ Glucose, Fluid ☐ T. Protein, Fluid
- ☐ Crystal Exam _____ Source

THERAPEUTIC DRUGS

LAST DOSE DATE / TIME _____

- ☐ Carbamazepine (Tegretol)
- ☐ Depakene (Valporic Acid)
- ☐ **Digoxin (Lanoxin)**
- ☐ Dilantin (Phenytoin)
- ☐ Lithium
- ☐ Phenobarbital

GENERAL LABORATORY

- ☐ Albumin
- ☐ Alkaline Phosphatase
- ☐ Amylase
- ☐ B12 ☐ B12 / Folate
- ☐ Bilirubin, Direct
- ☐ Bilirubin, Total
- ☐ **BNP, NT Pro** (B - type Natriuretic Peptide)
- ☐ BUN
- ☐ **CA 125**
- ☐ Calcium
- ☐ **Cholesterol**
- ☐ Cortisol
- ☐ CK (CPK)
- ☐ Creatinine
- ☐ CRP ☐ CRP High Sensitivity
- ☐ Estradiol ☐ Estradiol (LC-MS/MS)
- ☐ DHEA - Sulfate
- ☐ **Ferritin**
- ☐ Folate, serum
- ☐ FSH (Follicle Stimulating Hormone)
- ☐ **GGT (Gamma GT)**
- ☐ **Glucose** ___ **F** ___ **(hr pp)**
- ☐ Glucose Tolerance _____ hrs.
- ☐ Glucose 50 gm load
- ☐ HCG Qual (Pregnancy Test)
- ☐ **HCG, Quant.**
- ☐ **HDL**
- ☐ **Hemoglobin A1C (Glyco Hgb)**
- ☐ Homocysteine (serum)
- ☐ IgG ☐ IgM ☐ IgA
- ☐ Immunoelectrophoresis, serum
- ☐ Insulin
- ☐ Insulin Tolerance _____ hrs
- ☐ **Iron**
- ☐ **Iron / Transferrin w TIBC calc**
- ☐ **Iron Deficiency Profile (non - CMS)** (Iron, Transferrin, TIBC calc, % Sat, Ferritin)
- ☐ LDH
- ☐ **LDL, Direct**
- ☐ Lead Level
- ☐ Lipase
- ☐ Luteinizing Hormone (LH)
- ☐ **Magnesium**
- ☐ Myoglobin
- ☐ Phosphorus

GENERAL LABORATORY

- ☐ Potassium
- ☐ Prenatal Risk Quad Marker ☐ AFPMS only
- ☐ Progesterone
- ☐ Prolactin
- ☐ Protein Electrophoresis, Serum ☐ Reflex IFE
- ☐ **PSA**
- ☐ **PSA, Free (includes PSA)**
- ☐ PTH, Intact (includes CA)
- ☐ **T3 Uptake**
- ☐ **T Uptake and FTI (T3 uptake, T4, T7 calc**
- ☐ T3, Free
- ☐ T3, Total
- ☐ **T4 (Thyroxine)**
- ☐ **T4, Free (Free Thyroxine)**
- ☐ Testosterone, Total
- ☐ Testosterone, Total and calc Free (incl. SHBG)
- ☐ Testosterone, Total and measured Free (LC – MS/MS)
- ☐ Troponin T
- ☐ **TSH (ultrasensitive)**
- ☐ Uric Acid
- ☐ **Vitamin D 25 - OH**

MEDICARE SCREENING

ABN Required for possible frequency issues

- ☐ **Lipid Panel Screen (Chol, Trig, HDL)**
  Dx: Z13.6

Diabetic Screen:Select one
- ☐ **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

ORGAN / DISEASE PANELS

- ☐ Basic Metabolic Panel (Chem 8) (Na, K, Cl, CO2, Gluc, BUN, Creat, Ca)
- ☐ Comp. Metab. Panel (Chem 14) (Basic Metabolic plus Alb, TBili, AlkP, TP, AST, ALT)
- ☐ Hepatic Function Panel (Liver Panel) (Alb, TBili, DBili, APhos, TP, ALT, AST)
- ☐ **Acute Hepatitis Panel** (HAAb (IGM), HBcAb (IGM), HBsAG, HCAb)
- ☐ **Lipid Panel** (Chol, Tgl, HDL, Calc LDL, ratios)
- ☐ **Lipid Panel with Direct LDL if Trig > 400**
- ☐ Renal Function Panel (Na, K, Cl, CO2, Gluc, BUN, Creat, Ca, Alb, PO4)
- ☐ Obstetric Panel (non-CMS) (CBC plt & diff, HBSAg, Rubella, Syphilis scr, ABO / Rh, Ab scr)
- ☐ PIH Profile (non-CMS) (CBC plt & autodiff, BUN, Creat, ALT, AST, Uric Acid)
- ☐ PIH Profile No CBC (inc LDH w the above)

MICROBIOLOGY (ID & Sens reflex if indicated)

SOURCE / SITE REQUIRED

- ☐ Culture, AFB w / smear
- ☐ Culture, Blood
- ☐ Culture, Fungus
- ☐ H.pylori Stool Antigen
- ☐ Herpes Simplex 1 & 2 DNA Probe
- ☐ Culture, Routine (w Gram stain) ☐ Anaerobic
- ☐ Culture, Stool (Campy, Sal / Shig, E. Coli)
- ☐ Culture, Strep Screen ☐ Sens. Req
- ☐ **Culture, Urine** ☐CC ☐ Cath ☐ Void
- ☐ C.difficile Toxigenic ☐ w Lactoferrin
- ☐ **Fecal Occult Blood (FOB)**
- ☐ Giardia Antigen
- ☐ Lactoferrin / WBCs stool
- ☐ Ova & Parasite
- ☐ Rotavirus Antigen
- ☐ RSV Rapid Antigen

MISCELLANEOUS TESTS(Lab & Test code)

1PORDER

4868
11/22