LIFESPAN LABORATORIES
Homedraw Department
(401) 793-4740

Homedraw Requisition

☐ **Standing Order** ☐ **One Time Order**

MNT	SST	RED	LAV	BLU	GRN	URIN	SWB	PRB	PAP	OTH

Complete this box for standing orders only
☐ **New Standing Order** ☐ **Renew Standing Order** ☐ **Discontinue Standing Order**

Order start date: / / **Order end date:** / / (6 months if none indicated) **Frequency:** (PRN not acceptable frequency)

FOR LAB USE ONLY

Client:

Phone:

Fax:

Ordering Physician:

Physician Office Phone #:

Physician Address:

Physician Office Fax #:

City/State/Zip

SERVICE CODE:
LHD

PHLEBOTOMIST USE ONLY

Phlb Init: Date: Time: ☐ am ☐ pm

PATIENT INFORMATION

Last First M.I. ☐ **Male** ☐ **Female**
Name

Address

City State Zip

Phone DOB SS #

☐ MD INTERFACED DO NOT FAX

☐ STAT

Nurse Name:
Nurse cell Phone #:
CC COPY TO:_____

OTHER NOTES:

INSURANCE INFORMATION

PRIMARY INS NAME

Policy # Group #

SECONDARY INS NAME UNITED

Policy # Group #

Phlebotomist Notes: **please provide dx codes**

TRAVEL FEE BILLING ONLY

Please check one:	Price	Service Code
☐ P9603 TRAVEL FEE		76063577
☐ P9604 TRAVEL FEE		76063569

When Ordering Tests For Medicare And Medicaid Patients, Please Select Only Those Tests Which Are Medically Necessary For The Diagnosis Or Treatment Of The Patient. Medicare Does Not Pay For Routine Screening Tests.

ICD-10 CODES (Enter All that Apply) 1 2 3 4 5 6 7 8 9

Asterisk (★) indicates a Medicare Advance Beneficiary Notice (ABN) may be needed if condition is not covered by applicable ICD-10-CM codes / DXs. Check RI Medicare Rules for coverage limitations.

AMA APPROVED PANELS — **ICD-10 / DX**

- ☐ **Basic Metabolic Panel** (**GBCLytes + Ca**) ★ ____
- ☐ (**Glucose**, BUN, Creat, Na, K. Cl, CO_2, Ca)
- ☐ **Electrolyte Panel** (Na, K, CL, CO_2) ____
- ☐ **Liver (Hepatic) Function Panel** (**LFTs**)
- ☐ (Alb, Alk Phos, AST, ALT, T Bili, D Bili, T Protein) ____
- ☐ **Lipid Panel** (Chol, Trig, HDL, LDL calc) ★

INDIVIDUAL — **ICD-10 / DX**

- ☐ A1C ★ ____
- ☐ Albumin ____
- ☐ Alk Phosphatase ____
- ☐ ALT (SGPT) ____

TESTS — **ICD-10 / DX**

- ☐ AST (SGOT) ____
- ☐ Bilirubin, Direct ____
- ☐ Bilirubin, Total ____
- ☐ BUN ____

INDIVIDUAL — **ICD-10 / DX**

- ☐ Calcium, Total ____
- ☐ CO2 ____
- ☐ Chloride ____
- ☐ CBC/PLT ★♦ ____
- ☐ CBC/PLT/DIFF ★♦ ____
- ☐ Creatinine ____
- ☐ Digoxin ★ ____
- ☐ Ferritin ★ ____
- ☐ Glucose ★ ____
- ☐ Hematocrit ★ ____
- ☐ Hemoglobin ★ ____

ICD-10 / DX

- ☐ IRON ★ ____
- ☐ Magnesium ★ ____
- ☐ Phenytoin (Dilantin) ____
- ☐ Phosphorus ____
- ☐ Potassium ____
- ☐ Protein, Total ____
- ☐ PT(Prothrombin Time) ★ ____
- ☐ PTT ★ ____
- ☐ Sedimentation Rate ★ ____
- ☐ Sodium ____
- ☐ TIBC ★ ____

TESTS — **ICD-10 / DX**

- ☐ Vit D3 ★ (VitD25) ____
- ☐ Vit B12 ★ ____
- ☐ U Microalbumin ____
- ☐ Urinalysis ____
- ☐ Urine Culture ★ ♦ ____

ADDITIONAL TESTS (Please Print)

- ☐ _____ ____
- ☐ _____ ____
- ☐ _____ ____
- ☐ _____ ____
- ☐ _____ ____

♦ Reflexive testing may be performed when indicated and may carry an additional charge

To the Ordering Physician/AHP: Federal Regulations require all laboratories to obtain written authorization for any laboratory test ordered.

Please sign this form to verify that all tests indicated were ordered by you AND that the patient qualifies for homebound status as defined by Medicare. In addition, please provide all appropriate diagnostic ICD-10 Code(s).

_____ _____
Physician/AHP Signature **Date**

Return Within 24 Hours To: **Lifespan Laboratories Homedraw Department**
148 West River Street, Suite 4, Providence, RI 02904