General Lab Requisition

Patient's Last Name	First	Middle	Birth Date **(Required)**	Legal Sex

Outside Patient Number	Outside Specimen Number	Send Report To
Ordering Provider		Address
Phone Number	Diagnosis/ICD Code **(Required)**	Phone/Fax

Required Speciment Information:

DATE COLLECTED: _____ / _____ / _____ ☐ Whole Blood ☐ Serum/Plasma ☐ Urine

TIME COLLECTED: _____ : _____ AM/PM ☐ Skin ☐ Other _____

CHEMISTRY

- ☐ Albumin (LAB45)
- ☐ Alkaline Phosphatase, Serum (LAB112)
- ☐ ALT (SGPT) (LAB132)
- ☐ Amylase Serum (LAB48)
- ☐ AST (SGOT) (LAB131)
- ☐ Basic Metabolic Panel (BMP)*(LAB15)
  **BMP includes: Electrolytes (CO2, Cl, Na, K) Glucose, BUN, Creat, Calcium*
- ☐ Bilirubin (Unconj/Conjugated) (LAB3606)
- ☐ Beta-Hydroxybutyrate (LAB2844)
- ☐ BUN (LAB140)
- ☐ Calcium Level, Total (LAB813)
- ☐ Calcium Ionized (LAB54)
- ☐ Chloride Level (LAB59)
- ☐ Cholesterol (LAB60)
- ☐ Creatine Kinase (CK) (LAB62)
- ☐ Carbon Dioxide, Total (CO2) (LAB55)
- ☐ Comprehensive Metabolic Panel* (LAB17)
  **CMP Includes: Electrolytes (CO2, Cl, Na, K), Glucose, BUN,Creat, Calcium, AST, ALT, ALK PHOS, Protein, Albumin*
- ☐ C-Reactive Protein (CRP) (LAB149)
- ☐ Creatinine (LAB383)
- ☐ Electrolytes (CO2, Cl, Na, K) (LAB16)
- ☐ Ferritin (LAB68)
- ☐ Gammaglutamyl Transferase (GGT) (LAB85)
- ☐ Glucose Level (LAB3084)
- ☐ Immunoglobulin E Level (LAB74)
- ☐ Immunoglobulins Panel (IgA, IgG, IgM) (LAB3213)
  IgA (LAB73) IgG (LAB71) IgM (LAB72)
- ☐ Iron Level (LAB94)
- ☐ Iron Profile (Fe, TIBC, % Saturation) (LAB829)
- ☐ Lactic Acid Blood (LAB3574)
- ☐ Lactate Dehydrogenase (LDH) (LAB96)
- ☐ Lipase Level (LAB3253)
- ☐ Lipid Panel (Chol, Trig, LDL, HDL) (LAB18) ❑ Magnesium Serum (LAB103)
- ☐ Infectious Mono Screen (Monospot) (LAB3216)
- ☐ Phosphorous Serum (LAB113)
- ☐ Potassium Level (LAB114)
- ☐ Protein, Total (LAB118)
- ☐ Sodium Level (LAB122)
- ☐ Triglycerides (LAB134)
- ☐ VMA/HVA, Serum (LAB3548)
- ☐ Uric Acid (LAB141)

COAGULATION

- ☐ D-Dimer (LAB313)
- ☐ Fibrinogen (LAB314)
- ☐ Partial Thromboplastin Time (LAB325)
- ☐ Prothrombin Time + INR (LAB320)

HEMATOLOGY

- ☐ CBC* (LAB294)
- ☐ CBC with Differential (LAB293)
- ☐ Erythrocyte Sedimentation Rate (ESR)(LAB322)
- ☐ Hematocrit (LAB289)
- ☐ Platelet Count (LAB301)
- ☐ Reticulocyte Count (LAB296)
- ☐ Sickle Cell Screen (LAB339)
- ☐ White Blood Cell (WBC) Count (LAB299)
  **CBC Includes: RBC, HGB, HCT, MCV, MCH, MCHC, RDW, WBC, Platelet Count, MPV*
  ***CBC with Differential Includes: Polys, Bands, Lymphocytes,Monocytes, Eosinophils, Basophils in addition to CBC*

ENDOCRINOLOGY

- ☐ 17-Hydroxyprogesterone (LAB720)
- ☐ Cortisol (LAB61)
- ☐ Estradiol (LAB523)
- ☐ Follicle Stimulating Hormone (FSH) (LAB86)
- ☐ Hemoglobin A1C (LAB90)
- ☐ IGF Binding Protein 3 (LAB3205)
- ☐ Insulin Level (LAB527)
- ☐ Insulin-Like Growth Factor 1 (LAB526)
- ☐ Luteinizing Hormone (LAB87)
- ☐ Testosterone Total by LC/MS (LAB3490)
- ☐ Thyroid Stimulating Hormone (TSH) (LAB129)
- ☐ Thyroxine (T4), Free (LAB127)
- ☐ Triiodothyronine (T3), Free (LAB3061)
- ☐ Triiodothyronine (T3), Total (LAB136)
- ☐ Vitamin A (LAB580)
- ☐ Vitamin D, 25-Hydroxy Level, Total (LAB535)
- ☐ Vitamin E (LAB130)

MICROBIOLOGY

- ☐ Adenovirus PCR Quant, Blood (LAB2479)
- ☐ BK Virus PCR Quant, Blood (LAB1374)
- ☐ Blood Culture (Bacterial), Aerobic (LAB2525)
- ☐ Blood Culture (Bacterial), Aerobic + Yeast (LAB2526)
- ☐ Blood Culture (Bacterial), Anaerobic (LAB2527)
  - ☐ Check if Lab needs to extend incubation time for yeast or slow growing organisms.
- ☐ CMV PCR Quant, Blood (LAB2487)
- ☐ CSF Meningitis/Encephalitis PCR Qual Panel (LAB2421)
- ☐ EBV PCR Quant, Blood (LAB2987)

STOOL TESTS

- ☐ C. difficile Antigen and Toxin, plus Reflex PCR (LAB2535)
- ☐ Calprotectin, Stool (LAB2392)
- ☐ Rapid Stool Infectious Diarrhea PCR Panel (LAB2451)
- ☐ Stool Culture (LAB223)
- ☐ Stool Giardia + Crypto EIA (LAB1319)

URINE TESTS

- ☐ Calcium, Urine Random (LAB371)
- ☐ Creatinine, Urine Random (LAB384)
- ☐ hCG, Urine Pregnancy Test (LAB437)
- ☐ Microalbumin/Creatinine Urine (LAB689)
- ☐ Osmolality, Urine (LAB420)
- ☐ Potassium, Urine (LAB434)
- ☐ Protein, Urine (LAB439)
- ☐ Sodium, Urine (LAB444)
- ☐ Urine Culture (LAB239)
- ☐ Urinalysis (LAB1968) or ❑ UA w/Micro (LAB348)
- ☐ Culture if indicated?

Collection Method: _____

THERAPEUTIC DRUG MONITORING

- ☐ 10-OH Oxcarbazepine Level (LAB2687)
- ☐ Carbamazepine (Tegretol) Level (LAB21)
- ☐ Cyclosporin Level (LAB874)
- ☐ Everolimus Level (LAB3012)
- ☐ Gabapentin (Neurontin) (LAB470)
- ☐ Lamotrigine (Lamictal) (LAB475)
- ☐ Levetiracetam (Keppra) (LAB477)
- ☐ Methotrexate Level Blood (LAB481)
- ☐ Methotrexate Level CSF (LAB2434)
- ☐ Phenobarbital (LAB30)
- ☐ Phenytoin (Dilantin) (LAB31)
- ☐ Posaconazole Level (LAB3397)
- ☐ Sirolimus Level (LAB875)
- ☐ Tacrolimus (FK506) (LAB876)
- ☐ Topiramate (Topamax) (LAB498)
- ☐ Valproic Acid (Depakene) (LAB24)
- ☐ Voriconazole Level (LAB3552)
- ☐ Zonisamide (Zonegran) Level (LAB504)

VIROLOGY

- ☐ Hepatitis A Antibody, Total (LAB797)
- ☐ Hepatitis B Core Antibody, IgM (LAB549)
- ☐ Hepatitis B Surface Antibody (LAB472)
- ☐ Hepatitis B Surface Antigen (LAB471)
- ☐ Hepatitis C Antibody (LAB868)
- ☐ HIV Antigen and Antibody (LAB3170)
- ☐ Varicella Zoster Immune Status (LAB3537)

OTHER TESTING

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Provider Print Name:_____ **Provider Signature:** _____ **Date:** _____ **Time:**_____

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LAB REQUISITION - GENERAL OUTSIDE

PATIENT LABEL

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call (206) 987-2617.

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Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.2.441
SEATTLE, WA 98105