

Laboratory Services Outpatient Requisition



Patient Instructions:

Visit www.wellspan.org for locations and hours of operation

Please bring photo ID and insurance card.

Date to be done: _____

If fasting is required [marked with **(F)**], please do not eat or drink (except for water) for 10-12 hours prior to test

Confirmation #: _____

↓ ↓ All Asterisk (*) fields are required (please print). Complete ALL fields for specimen drop-offs ↓ ↓

Patient Full Name*		DOB*	Sex (Circle)*	SSN or MRN (Circle)
Last	First	M / D / Y Y Y Y	M F	
Practice Name and Location*		Patient Address		Collected By: Name _____ Date _____ Time _____
Ordered By (Printed)* Assumes responsibility for tests ordered		Add'l copy to: (Physician Full Name) does not remove ordering physician responsibility or guarantee receipt of results		Attach Insurance Info
Last	First	Last	First	
Physician Signature (Please Print Name Above)		Code Key: (F): Fasting Required (No food or drink, except water for 10-12 hours prior to test) ◆: Additional info * : Required field	Standing Order	
			Frequency:	Duration:
		<input type="checkbox"/> weekly	<input type="checkbox"/> 3 mos	
		<input type="checkbox"/> monthly	<input type="checkbox"/> 6 mos	
		Other _____	<input type="checkbox"/> 1 yr	
Diagnosis Codes must be provided*				

Panel Tests:	Panel includes:	Additional Tests/Instruction:
<input type="checkbox"/> Acute Hepatitis Panel	HEP ACUTE (HBsAg, HB Core IgM Ab, HA IgM Ab, HC IgG Ab)	
<input type="checkbox"/> Chronic Hepatitis Panel	HEP CHRON (HBsAg, HB Core Ab, HB Core IgM Ab, HC IgG Ab, HBeAg)	
<input type="checkbox"/> Basic Metabolic Panel	BASIC (CO2, Cl, Na, K, Glu, BUN, Ca, Crea)	
<input type="checkbox"/> Comprehensive Metabolic	COMP (Basic Metabolic tests, Alb, Tbili, Alk Phos, TP, AST, ALT)	
<input type="checkbox"/> Electrolytes	LYTES (CO2, Cl, Na, K)	
<input type="checkbox"/> Hepatic (Liver) Function	LF (TBILI, DBILI, AST, Alk Phos, ALT, Alb, TP)	
<input type="checkbox"/> Lipid Panel (F)	LIPID (Chol, HDL, Trig, Chol/HDL Ratio, Calc LDL or Direct LDL if indicated)	
<input type="checkbox"/> Prenatal Panel	PNT or PNT GH (CBC, RPR, HBsAg, HIV, Rubella IgG, Type&Rh, Ab Scrn, PT Hx Ck)	
<input type="checkbox"/> Renal Function Panel	RENAL (Alb, Ca, CO2, Cl, Crea, Glu, Phos, K, Na, BUN)	

**** Important Notice **** Tests listed in BOLD have limited coverage. Provide appropriate medical necessity documentation. The patient may be responsible for payment. Medicare patients may be required to sign an ABN for non-covered services.

<input type="checkbox"/> Albumin Level ALB <input type="checkbox"/> Alpha Feto Protein Tumor AFP TUMOR <input type="checkbox"/> Alkaline Phosphatase ALK PHOS <input type="checkbox"/> ALT (SGPT) ALT <input type="checkbox"/> Amylase AMY <input type="checkbox"/> Anti Nuclear Antibodies Screen © ANA <input type="checkbox"/> Anti Phospholipid Evaluation APS Incl Cardio/Lupus Coag/PS <input type="checkbox"/> Anti-Sm/RNP, Ro/La (Qualitative) ENA ABS <input type="checkbox"/> AST (SGOT) AST <input type="checkbox"/> B-Type Natriuretic Peptide BNP Bilirubin Testing: <input type="checkbox"/> Neonatal-total NBILI <input type="checkbox"/> Direct bilirubin DBILI <input type="checkbox"/> C Peptides (w/o glucose) CPEP <input type="checkbox"/> CA 19-9 CA 19-9 <input type="checkbox"/> CA 27.29 CA 27.29 <input type="checkbox"/> CA 125 CA 125 <input type="checkbox"/> Calcium Level Total CA <input type="checkbox"/> CBC & Auto Diff; © CBC <input type="checkbox"/> CBC Without Diff WCBC <input type="checkbox"/> CEA (Carcinoembryonic Ag) CEA Cholesterol <input type="checkbox"/> CHOL (Total) <input type="checkbox"/> HDL CHOL <input type="checkbox"/> <input type="checkbox"/> LDL DIRECT <input type="checkbox"/> TRIG(F) <input type="checkbox"/> CK + CKMB CKMB <input type="checkbox"/> CK CK <input type="checkbox"/> Cortisol CORTISOL <input type="checkbox"/> Complement C3 C3 <input type="checkbox"/> Complement C4 C4 <input type="checkbox"/> Complement Total CH 50 CH50 CRP Testing: <input type="checkbox"/> CRP Quant <input type="checkbox"/> CRP High Sens <input type="checkbox"/> Creatinine CREAT <input type="checkbox"/> DHEA Sulfate DHEAS <input type="checkbox"/> EBV IgG Antibody EBV IGG <input type="checkbox"/> EBV IgM Antibody EBV IGM <input type="checkbox"/> Endomysial IgA Antibody ENDO AB <input type="checkbox"/> Estradiol 17-Beta Level ESTRADIOL <input type="checkbox"/> Factor II (Proth) Mutation PROTH MUT	<input type="checkbox"/> Factor V Leiden FACT V GEN <input type="checkbox"/> Ferritin FERRITIN <input type="checkbox"/> FK-506 (Tacrolimus) FK-506 <input type="checkbox"/> Folate Level FOLATE <input type="checkbox"/> Follicle Stim Hormone FSH <input type="checkbox"/> GGTP GGTP <input type="checkbox"/> Glucose Fasting (F) GLUF <input type="checkbox"/> Glucose Non-Fasting GLUR <input type="checkbox"/> HCG Quant Oncology HCG ONCO <input type="checkbox"/> Hep B Core IgM Ab HBCAB IGM <input type="checkbox"/> Hep B Early Antigen HBEAG <input type="checkbox"/> Hep B Surface Antibody HBSAB <input type="checkbox"/> Hep B Surface Antigen HBSAG <input type="checkbox"/> Hep C Antibody HCVAB <input type="checkbox"/> Hep C Quant by PCR HCV PCR <input type="checkbox"/> Herpes 1 & 2 IgG Ab (Serum) HERPES IGG <input type="checkbox"/> Hgb A1C (Glycohemoglobin) HGB A1C <input type="checkbox"/> HIV 1/2 Ag/Ab Progressive HIV <input type="checkbox"/> HIV Quant byPCR HIV PCR VL <input type="checkbox"/> HLA B27 HLA B27 <input type="checkbox"/> Homocystine HOMOCYST <input type="checkbox"/> Immunofixation (serum) IMMUNOFIX <input type="checkbox"/> Iron Level FE <input type="checkbox"/> Iron +Transferrin + Sat IRON + <input type="checkbox"/> Immunoglobulin, G,A,M IMMUN QUAN <input type="checkbox"/> Insulin Level-w/o glucose INSULIN <input type="checkbox"/> LDH LDH <input type="checkbox"/> Lead – Blood LEAD <input type="checkbox"/> Lipase Level LIP <input type="checkbox"/> Luteinizing Hormone LH <input type="checkbox"/> Lyme IgG & IgM Ab; © LYME AB <input type="checkbox"/> Magnesium Level MG <input type="checkbox"/> Albumin/Creatinine (Urine) MALB/CREAT <input type="checkbox"/> Mononucleosis Screen MONO <input type="checkbox"/> Occult Blood Diag fecal FE OB <input type="checkbox"/> Occult Blood Scrn fecal FE OBSC <input type="checkbox"/> Parathyroid Hormone PTH INTACT	<input type="checkbox"/> Phosphorus Level PHOS <input type="checkbox"/> Potassium Level K <input type="checkbox"/> Prealbumin PREALB <input type="checkbox"/> Pregnancy BHCG Qnt PREG <input type="checkbox"/> Progesterone PROGEST <input type="checkbox"/> Prolactin PROLACTIN <input type="checkbox"/> Protein, Total TP Protein Electrophoresis: for: <input type="checkbox"/> Myeloma <input type="checkbox"/> Screen Select: <input type="checkbox"/> Non-Progressive-EP <input type="checkbox"/> Progressive PSA Testing (Check box and add ICD) <input type="checkbox"/> PSA Annual Screen Total ICD _____ <input type="checkbox"/> PSA Diag Total-Continuing Care ICD _____ <input type="checkbox"/> PSA Free+Total ICD _____ PSAII <input type="checkbox"/> PT / INR PT <input type="checkbox"/> PTT PTT <input type="checkbox"/> Reticulocyte Count RETIC <input type="checkbox"/> Rheum Factor Quant RHEUM FACT <input type="checkbox"/> RPR Screen; © RPR <input type="checkbox"/> Rubella IgG Ab RUBELLA IGG <input type="checkbox"/> Rubeola IgG Ab RUBEOLA IGG <input type="checkbox"/> Sedimentation Rate SED RATE <input type="checkbox"/> Testosterone, Total TESTOST T <input type="checkbox"/> Testosterone, Free TESTOST F <input type="checkbox"/> Thyroglobulin, Quant THYRO FACT <input type="checkbox"/> Thyroid Antibodies THYROID AB <input type="checkbox"/> Thyroid Peroxidase Ab TPO AB <input type="checkbox"/> Free T3 FREE T3 <input type="checkbox"/> T3 Total T3 <input type="checkbox"/> TSH-if abn, Free T4 © TSH PLUS <input type="checkbox"/> TSH TSH <input type="checkbox"/> Free T4 FREE T4 <input type="checkbox"/> T4 Total T4 <input type="checkbox"/> Urea Nitrogen, Blood BUN <input type="checkbox"/> Uric Acid URIC <input type="checkbox"/> Vitamin B12 VIT B 12 <input type="checkbox"/> Vitamin D 25 Total VIT D 25 <input type="checkbox"/> Varicella Zoster IgG VZ IGG
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Patient Name _____

Date of Birth _____

****Please complete ALL fields on reverse****

To prepare for your laboratory visit, or find the nearest collection center, visit www.wellspanlabs.org

Adams County/Northern Maryland Outpatient Collection Centers

Center	Address	Phone	Fax	Hrs of Operation: closed Sun & Holidays
Aspers	2060 Carlisle Road, Aspers	339-2577	677-4580	M-Th 7am-4:30pm; F 7-3:30pm; Closed Sat
Fairfield	4910A Fairfield Road, Fairfield	642-8229	None	M-F 7:30am-11:30am; Closed Sat
Gettysburg Hospital	147 Gettys Street, Gettysburg	337-4483	337-4194	M-F 7am-8pm; Sat 7am-12pm
Thurmont	52 Water St., Thurmont, MD	301-271-3535	None	M-F 7:30am-11:30am; Closed Sat
Adams Health Ctr	40 V-Twin Dr., Gettysburg	339-2605	339-2609	M-F 7am-4pm; Closed Sat

York County Outpatient Collection Centers

Center	Address	Phone	Fax	Hrs of Operation: closed Sun & Holidays
Apple Hill Lab	25 Monument Rd., Suite 198, York	741-8190	741-8059	M-F 6 am-6 pm; Sat 7-11 am
Dover	4020 Carlisle Rd., Dover	851-6490	851-6499	M,Tu,Th,F 6 am-2 pm; W 6 am-6 pm; Closed Sat
East Berlin	105 Fourth St., East Berlin	812-7350	259-6057	M-F 6:00 am- 12:00 pm; Closed Sat
Hanover	Northpointe Plaza,1150 Carlisle St Hanover	(877) 935-8430	633-7770	M,Tu,W,F 6 am-1 pm; Th 6 am-6 pm; Sat 7-11 am
Hayshire	2775 North George St., York	812-7300	846-5346	M,Tu,W,F 6 am-2 pm; Th 6 am-6 pm; Sat 7-11 am
Queensgate	Queensgate Shopping Center, York	812-5030	851-2300	M-F 6 am-2 pm; Closed Sat
Stonebridge	13515 Wolfe Rd., New Freedom	812-2520	812-2529	M,W,Th,F 6 am-2 pm; Tu 6 am-6 pm; Sat 7-11 am
Stonybrook	4222 Lincoln Highway, York	812-2900	812-2905	M,Tu,Th,F 6 am-2 pm; W 6 am-6 pm; Sat 7-11 am
Valley Green	1790 Old Trail Road, Suite E, Eppers	938-3382	932-3441	M-F 6 am-1 pm; Closed Sat
Westgate	Westgate Plaza,1550 Kenneth Rd,York	851-7020	764-2587	M,Tu 6 am-6 pm; W,Th,F 6 am-2 pm; Sat 7-11 am
Windsor	3065 Windsor Rd, Red Lion	851-1765	851-1770	M,Th 6 am-6 pm; Tu,W,F 6 am-2 pm; Sat 7-11 am
York Hospital	1001 S George St, York	851-2547	851-2707	M-F 7:30 am-4 pm; Closed Sat, Sun & Holidays

Reflex Testing: The Laboratory will perform and bill for reflex tests automatically when the reflex criteria have been met. Reflex tests have been approved by the Medical Executive Committee and are noted with an @ on the lab requisition. Refer to www.wellspanlabs.org for specific details on reflex tests.

Microbiology, Blood Bank, Urine and Additional Lab Tests

◆Date of Collection _____ Time of Collection _____

Gestational Screens	Abscess, Fluid, Wound and Blood Culture	Urine Specimen
<input type="checkbox"/> QUAD SCRIN ◆ _____ <input type="checkbox"/> AFP ONLY ◆ Delivery Date _____ By: <input type="checkbox"/> LMP <input type="checkbox"/> Ultrasound Ethnic Origin _____ # Fetuses _____ Insulin Dependent DM? <input type="checkbox"/> Y <input type="checkbox"/> N Initial or Repeat specimen(Circle) History of NTD? <input type="checkbox"/> Y <input type="checkbox"/> N if Y: _____ Hx Down Syn? <input type="checkbox"/> Y <input type="checkbox"/> N if Y: _____ Maternal Wt. _____ Egg Donor? <input type="checkbox"/> Y <input type="checkbox"/> N DOB: _____ <input type="checkbox"/> Pregnancy Glucose Screen PGS <input type="checkbox"/> 3 hour Glucose Tolerance GTT3	<input type="checkbox"/> Abscess & gram stain ◆ _____ C ABS <input type="checkbox"/> Body Fluid & gram stain ◆ _____ C FL <input type="checkbox"/> Tissue & gram stain ◆ _____ C TISS <input type="checkbox"/> Wound & gram stain ◆ _____ C WND ◆Source <input type="checkbox"/> Anaerobic Culture C AN [Order with any source above] <input type="checkbox"/> Blood Culture C BLD <input type="checkbox"/> Fungus Blood Culture C BLD F <input type="checkbox"/> CSF & Gram Stain ◆ C CSF ◆Source Uro-Genital Specimen <input type="checkbox"/> Chlamydia (check source) ◆ CHLAM PCR <input type="checkbox"/> Gonorrhea (check source) ◆ GC PCR ◆ <input type="checkbox"/> Cerv <input type="checkbox"/> Ureth <input type="checkbox"/> Urine <input type="checkbox"/> ThinPrep <input type="checkbox"/> Group B Strep Screen BSB DNA Source: Vaginal/rectal <input type="checkbox"/> Vaginosis/Vaginitis Panel VAG PANEL for BV, Trichomonas and Yeast	<input type="checkbox"/> Urinalysis ◆ UA Microscopic performed if indicated(YH) <input type="checkbox"/> Urinalysis; Culture performed, if indicated◆ UACX <input type="checkbox"/> Urinalysis Microscopic UAUTO <input type="checkbox"/> Urine Culture ◆ C U ◆Source (check below) <input type="checkbox"/> Midstrm <input type="checkbox"/> Cath Straight <input type="checkbox"/> Cath Indwell <input type="checkbox"/> Cysto <input type="checkbox"/> Random <input type="checkbox"/> Other _____ <input type="checkbox"/> Albumin/Creatinine ALB/CREAT Protein Electrophoresis Urine: <input type="checkbox"/> Non-Progressive-UEP <input type="checkbox"/> Progressive <input type="checkbox"/> Protein Random Urine UPROT <input type="checkbox"/> Urine Cytology◆ PATHOLOGY NON GYN ◆Source _____ Clin History _____ Urine Timed Specimen <input type="checkbox"/> Amylase Timed _____ hr. AMY T <input type="checkbox"/> Calcium 24 Hr CA 24 <input type="checkbox"/> Catecholamines Fract 24 CAT F 24 <input type="checkbox"/> Citrate 24 Hr CIT 24 <input type="checkbox"/> Cortisol Free 24 Hr CORT 24 <input type="checkbox"/> Creatinine 24 Hr CREAT 24 <input type="checkbox"/> Creatinine Clearance CRCL Ht _____ Wt _____ Hr _____ <input type="checkbox"/> Hydroxyindoleacet. Acid24 SHIAA 24 <input type="checkbox"/> Magnesium 24 Hr <input type="checkbox"/> Metanephrines Total 24 Hr MET 24 <input type="checkbox"/> Oxalate 24 Hr <input type="checkbox"/> Phosphorus 24 Hr <input type="checkbox"/> Protein 24 Hr PRO 24 <input type="checkbox"/> Sodium 24 Hr <input type="checkbox"/> Urea 24 Hr UREA 24 <input type="checkbox"/> Uric Acid 24 Hr URIC 24 <input type="checkbox"/> Urisk Profile 24 Hr RISK 24 Ht _____ Wt _____ <input type="checkbox"/> VMA 24 Hr VMA 24
Glucose Tolerance Must Be Scheduled Glucose Tolerance Testing (Non-Pregnant) <input type="checkbox"/> 2 hour Post-Prandial Glucose 2HPP Pre-test meal: 2 pieces plain white toast; 1Tbsp jelly; 8oz juice <input type="checkbox"/> 2 hour Glucose Tolerance GTT2	Miscellaneous Culture <input type="checkbox"/> Enterococcus scrn - VRE ◆ C VRE <input type="checkbox"/> Fungus Dermatophytes ◆ C DERM F <input type="checkbox"/> Fungus & smear-Other ◆ C F <input type="checkbox"/> Gonorrhea (non genital)◆ C GC <input type="checkbox"/> Herpes PCR ◆ HSV PCR <input type="checkbox"/> MRSA screen-Non-nasal ◆ C MRSA <input type="checkbox"/> MRSA screen - Nasal MRSA PCR <input type="checkbox"/> MSSA/MRSA Scrn (PreOp) MSMRSA PCR <input type="checkbox"/> TB (Acid Fast) & smear ◆ C TB <input type="checkbox"/> Yeast Screen ◆ C YT ◆Source _____	Respiratory Specimen <input type="checkbox"/> Throat Screen GpA Strep GAS DNA <input type="checkbox"/> Sputum & gram stain C SP <input type="checkbox"/> Influenza A&B; RSV PCR INFL RSV PCR <input type="checkbox"/> Respiratory Virus Panel RESP PCR
Blood Bank – No Txn Expected (No BB Armband) <input type="checkbox"/> Type & Rh ABORH <input type="checkbox"/> Antibody scrn; reflex, if applicable ABSC <input type="checkbox"/> Type, Rh and Screen ABORH ABSC <input type="checkbox"/> Direct Antiglobulin Test. DAT.	Stool Specimen <input type="checkbox"/> C. Difficile Assay CDIFF PCR <input type="checkbox"/> E.coli Shiga Toxin AG SLT <input type="checkbox"/> Stool Culture C ST <input type="checkbox"/> Ova & Parasite PARA <input type="checkbox"/> Giardia/Cryptosporidia Ag CRYPTO GIARDIA <input type="checkbox"/> H. pylori Antigen FE HPYLORI <input type="checkbox"/> Rotavirus ROTA	
Testing for Possible Transfusion (BB Armband req'd) <input type="checkbox"/> Type and Crossmatch - 1 unit <input type="checkbox"/> Type and Screen (YH) TNS <input type="checkbox"/> Blood Bank Tube to Hold BB HOLD		