

Patient Demographics			Physician Information								
PATIENT NAME (Last) (First) (Middle)			Ordering Provider <b>First Name, Last Name &amp; Credentials</b> (Printed) NPI (stamp above) <b>First Name:</b> _____ <b>Last Name:</b> _____ <b>NPI:</b> _____								
ADDRESS			Copy Results to _____								
CITY STATE ZIP		Call Results to _____		Fax Results to _____							
HOME PHONE		SOCIAL SECURITY #		Priority <input type="checkbox"/> Stat <input type="checkbox"/> Routine <input type="checkbox"/> Standing Order							
DATE OF BIRTH		GENDER M F		Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____							
<b>INSURANCE INFORMATION</b> (Please attach secondary information) Insurance Co. (primary) _____ Subscriber Name _____ Subscriber's Date of Birth _____			Duration <input type="checkbox"/> 3 mos <input type="checkbox"/> 6 mos <input type="checkbox"/> 1 yr <input type="checkbox"/> Other _____ ICD-10 (Required) _____, _____, _____, _____ <b>Description</b> _____								
			<b>COLLECTION INFORMATION:</b> Collection Date _____ Time _____ Collector Name _____								
ID#	Group #	Plan Code	*Medicare generally does not cover routine screening tests. Please order organ/disease related panels only when all components are medically necessary. Tests listed in <b>BOLD</b> 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.								
GENERAL			THERAPEUTIC DRUG								
<input type="checkbox"/> Albumin <input type="checkbox"/> Alkaline Phosphatase (ALP) <input type="checkbox"/> Alpha Fetoprotein (AFP) <input type="checkbox"/> ALT <input type="checkbox"/> Amylase <input type="checkbox"/> ANA ® reflex to titer <input type="checkbox"/> aPTT <input type="checkbox"/> AST <input type="checkbox"/> <b>B-Type Natriuretic Peptide (B-NP)</b> <input type="checkbox"/> Basic Metabolic Panel (BMP) <i>(BUN, Calcium, Creatinine, Lytes, Glucose)</i> <input type="checkbox"/> Bilirubin, Direct <input type="checkbox"/> Bilirubin, Total <input type="checkbox"/> Blood Urea Nitrogen (BUN) <input type="checkbox"/> C-Reactive Protein (CRP) <input type="checkbox"/> C-Reactive Protein, high-sensitivity (hsCRP) <input type="checkbox"/> CA-19.9 <input type="checkbox"/> CA-27.29 <input type="checkbox"/> CA-125 <input type="checkbox"/> Calcium, Total <input type="checkbox"/> <b>CBC</b> <input type="checkbox"/> <b>CBC w/diff ®</b> <input type="checkbox"/> CEA <input type="checkbox"/> Complement C3 <input type="checkbox"/> Complement C4 <input type="checkbox"/> Comp Metabolic Panel <i>(BMP+, Albumin, ALP, ALT, AST, T Bil, TP)</i> <input type="checkbox"/> Cortisol <input type="checkbox"/> CK <input type="checkbox"/> Creatinine <input type="checkbox"/> Estradiol <input type="checkbox"/> <b>Ferritin</b> <input type="checkbox"/> Folate Level <input type="checkbox"/> Follicle Stim Hormone (FSH) <input type="checkbox"/> <b>GGT</b>			<input type="checkbox"/> <b>Glucose</b> <input type="checkbox"/> <b>Glucose, 1 hour (PGS)</b> <input type="checkbox"/> <b>Glucose, 2 hour</b> <input type="checkbox"/> <b>Glucose, 3 hour</b> <input type="checkbox"/> <b>HCG Quant</b> <input type="checkbox"/> <b>HCG Quant, Oncology</b> <input type="checkbox"/> <b>Hemoglobin A1C</b> <input type="checkbox"/> Hep B Core Ab <input type="checkbox"/> Hep B Surface Ab <input type="checkbox"/> Hep B Surface Ag <input type="checkbox"/> Hep C Ab <input type="checkbox"/> Hep C Quant by PCR <input type="checkbox"/> Hepatic Function Panel <input type="checkbox"/> <b>HIV 1 RNA</b> <input type="checkbox"/> <b>HIV Ag/Ab Progressive</b> <input type="checkbox"/> Immunoglobulin IgA, IgG, IgM <input type="checkbox"/> <b>Iron</b> <input type="checkbox"/> LDH <input type="checkbox"/> Lead <input type="checkbox"/> Lipase <input type="checkbox"/> <b>Lipid</b> (Cholesterol, HDL, LDL, Trig) <input type="checkbox"/> Lutenizing Hormone (LH) <input type="checkbox"/> Lyme Disease EIA reflex/Western Blot <input type="checkbox"/> Magnesium <input type="checkbox"/> <b>Parathyroid Hormone, Intact (PTH)</b> <input type="checkbox"/> Phosphorus <input type="checkbox"/> Potassium <input type="checkbox"/> Prealbumin <input type="checkbox"/> Prolactin <input type="checkbox"/> Protein, Electrophoresis progressive <input type="checkbox"/> Protein, Total <input type="checkbox"/> <b>PSA, Annual Screen</b> <input type="checkbox"/> <b>PSA, Diagnostic</b> <input type="checkbox"/> <b>PSA, Free &amp; Total</b> <input type="checkbox"/> <b>PSA, Progressive</b> <input type="checkbox"/> <b>PT/INR</b>			<input type="checkbox"/> Quantiferon Gold, TB Screen <input type="checkbox"/> Renal Panel <input type="checkbox"/> Rheumatoid Factor <input type="checkbox"/> RPR ® <input type="checkbox"/> Rubella <input type="checkbox"/> Sed Rate (ESR) <input type="checkbox"/> Sodium <input type="checkbox"/> T4, Free <input type="checkbox"/> T4, Total <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Testosterone <input type="checkbox"/> Testosterone, Free <input type="checkbox"/> Thyroglobulin <input type="checkbox"/> Thyroglobulin Ab <input type="checkbox"/> Thyroid Peroxidase Ab <input type="checkbox"/> Transferrin <input type="checkbox"/> <b>TSH</b> <input type="checkbox"/> <b>TSH progressive ®</b> <input type="checkbox"/> Uric Acid <input type="checkbox"/> Varicella zoster <input type="checkbox"/> <b>Vitamin B12</b> <input type="checkbox"/> <b>Vitamin D-25, total</b>			Dose Amount: _____ Dose Date/Time: _____ <input type="checkbox"/> Carbamazepine <input type="checkbox"/> <b>Digoxin</b> <input type="checkbox"/> Lithium <input type="checkbox"/> Phenobarbitol <input type="checkbox"/> Phenytoin (Dilantin) <input type="checkbox"/> Theophylline <input type="checkbox"/> Valproic <input type="checkbox"/> Vancomycin (Check one) <input type="checkbox"/> Random <input type="checkbox"/> Trough		
			MICROBIOLOGY								
			<input type="checkbox"/> Bacterial Vaginosis Panel <input type="checkbox"/> Blood Culture <input type="checkbox"/> C. difficile PCR <input type="checkbox"/> Chlamydia trachomatis <input type="checkbox"/> Giardia/Cryptosporidium antigen <input type="checkbox"/> Neisseria gonorrhoeae <input type="checkbox"/> MRSA DNA PCR <input type="checkbox"/> MRSA/MSSA PCR Screen (Pre-Op) <input type="checkbox"/> Mycoplasma genitalium <input type="checkbox"/> Ova and Parasite (stool)* <input type="checkbox"/> Sputum Culture <input type="checkbox"/> Stool Culture <input type="checkbox"/> Trichomonas vaginalis <input type="checkbox"/> Group A Strep DNA <input type="checkbox"/> Group B Strep DNA Source: _____ Body Site: _____ * Travel history, past/present resident of a developing country, past exposure to hook worms.								
			URINE								
			<input type="checkbox"/> Creatinine, 24 Hour <input type="checkbox"/> Creatinine Clearance <input type="checkbox"/> Albumin/Creatinine ratio <input type="checkbox"/> Protein, 24 Hour <input type="checkbox"/> Protein/Creatinine Urine ratio <input type="checkbox"/> Urinalysis <input type="checkbox"/> Urinalysis, culture if indicated <input type="checkbox"/> <b>Urine Culture</b>								
			RESPIRATORY VIRUS TESTING								
			<input type="checkbox"/> Influenza A, B, RSV, Covid (4-plex) <input type="checkbox"/> Respiratory Viral Panel Incl: Adenovirus, B. paraptussis, B. pertussis, Coronavirus, C. pneumoniae, Flu A, Flu B, Metapneumovirus, M. pneumoniae, Para influ 1-4, Rhinovirus/Enterovirus, RSV, SARS CoV-2 <input type="checkbox"/> SARS CoV-2** (See Instructions) <input type="checkbox"/> Other Respiratory Virus: _____ (will be sent to reference lab)								
			BLOOD BANK								
			<input type="checkbox"/> ABO/Rh <input type="checkbox"/> Antenatal RhIG Work Up <input type="checkbox"/> Blood Bank Pre-Admission <input type="checkbox"/> Direct Antiglobulin Test (DAT) <input type="checkbox"/> Type & Screen * For a Type & Screen, please put a blood bank wristband on the patient and transfer a blood bank ID sticker to the sample.								
OTHER TESTS/SPECIAL INSTRUCTIONS:											
			<b>**SARS CoV-2 Testing:</b> <input type="checkbox"/> First Responder <input type="checkbox"/> Pre-procedural <input type="checkbox"/> Symptomatic <input type="checkbox"/> Other _____								



## LABORATORY REQUISITION

[www.wellspanlabs.org](http://www.wellspanlabs.org)

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**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 all WellSpan Medical Executive Committees and are noted with an ® on the lab requisition. Refer to [www.wellspanlabs.org](http://www.wellspanlabs.org) for specific details on reflex tests.

**To view collection sites' hours and locations visit [www.wellspanlabs.org](http://www.wellspanlabs.org).**