Community Hospital Anderson

OUTPATIENT LABORATORY REQUEST

PATIENT IDENTIFICATION

Patient Name:	Collection Date:
Date of Birth: Sex:	Physician: Sex:
Social Security Number:	FAX Results To:
Insurance	Call Results To:
Employer	Copy of Report To:

CHECK PANELS OR TEST DESIRED

PANELS		**INDIVIDUAL TESTS**			
Chemistry Panels		**Hematology Tests**		**Urine & Body Fluids**	
Electrolytes Panel		CBC/PLT w/DIFF		Cerebral Spinal Fluid Profile	
Basic Metabolic Panel		CBC/PLT w/o DIFF		Urine Drug Screen w/ confirmations	
Comprehensive Metabolic Panel		Hematocrit		24 Hr Urine Creatinine Clearance	
Liver Panel		Hemoglobin		Routine Urinalysis (U/A)	
Renal Panel		Reticulocyte		Routine Urinalysis (U/A)- C&S if indicated	
Lipid Panel		Westergren Sed Rate		Random Urine Creatinine	
Chemistry Tests		**Coagulation Tests**		Random Urine Micro Albumin	
Amylase		Fibrinogen		Random Urine Total Protein	
B12		PT		Random Urine Creat/Micro Alb Ratio	
Bilirubin Fractions		PTT		Semen Analysis-Fertility	
CPK		Platelet Function		Semen Analysis-Post Vasectomy	
Estradiol		**Serology Tests**		Synovial Fluid Profile _____ Source	
Estrogen		Anti-HIV 1 & 2		**Microbiology Tests**	
Folate		Anti-DNA Antibody		C-Diff PCR	
FSH		Anti-Nuclear Antibody		Chlamydia (CT) DNA _____ Source	
GGT		C-Reactive Protein		Gonorrhea (GC) DNA _____ Source	
Glucose Post 1 hr Glucola		Hep A Ab ___ IgG ___ IgM		Wet Prep for Yeast _____ Source	
Hgb A1c		Hep B core IgM Ab		Trichomonas Ag _____ Source	
Iron		Hep B Surface Antigen		IFOB (Occult Bld)	
Iron Binding		Hep B Surface Antibody		Flu A&B PCR	
LDH		Hep C Antibody		MRSA PCR _____ Source	
LH		HEP C RNA		Stool Culture	
Lipase		Mono - Test		Ova & Parasite Routine	
Magnesium		Pregnancy Test Qualitative:		Rapid Group A Strep	
Phosphorus		___ Serum ___ Urine		Blood Cultures _____ QTY	
Potassium		HCG Quantitative		Routine Culture:	
PreAlbumin		RA Test		Type: _____	
Progesterone		RPR		Source: _____	
Prolactin		Rubella ___ IgG ___ IgM		Group B Strep Culture	
PSA___ Screen___ Diagnostic		Rubeola ___ IgG ___ IgM		**Pathology**	
T-3 total		**Blood Bank Tests**		Tissue Submitted:	
T-4		Type Rh		Cytology: _____ Source	
T-4 free		Indirect Coombs		PAP: _____ Source	
Testosterone		Direct Coombs		PAP w/ _____GC _____CT _____HPV rflx	
TSH		Antibody Titer			
Uric Acid		Type and Screen			
Vitamin D 25 Hydroxy		Type and Crossmatch		**Diagnosis:**	
Therapeutic Drugs		_____ # units			
Carbamazepine		____ PC ____ PLT ____ FFP			
Depakene		_____ Preop/TxDate			
Lithium		**Other Tests Needed:**		**Physician Signature** **Date**	
Phenobarbital					
Theophylline					
Pain Management UDS * * *					
***submit a medication list					

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Theophylline					
Pain Management UDS * * *					
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