

PATIENT DEMOGRAPHIC AREA

LEGAL NAME \_\_\_\_\_

UVMC - MRN \_\_\_\_\_ DOB \_\_\_\_\_ GENDER  M  F  X

PREFERRED NAME \_\_\_\_\_ SSN (LAST 4) \*OPTIONAL \_\_\_\_\_

Ordering Provider: \_\_\_\_\_  
(first & last name)

Ordering provider please provide signature below\*

ACCOUNT INFORMATION / SUBMITTER CODE: **HSH - Springfield Hospital (802) 885-2151**

ADDITIONAL COPY OF REPORT TO (First and Last Name Required) \_\_\_\_\_

CLIENT I.D. \_\_\_\_\_

**BILLING INFORMATION**

RESPONSIBLE PARTY NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_

ADDRESS (STREET, TOWN, STATE, ZIP CODE) \_\_\_\_\_

MEDICARE NO. \_\_\_\_\_ MEDICAID NO. \_\_\_\_\_ MANAGED CARE MEDICAID NO. \_\_\_\_\_ STATE \_\_\_\_\_

INSURANCE COMPANY NAME \_\_\_\_\_ CERT. NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ SUBSCRIBER'S DOB \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**DIAGNOSIS INFORMATION**

Clinical diagnosis (ICD-10), signs, symptoms, pertinent history no R/O. Medicare has rules regarding medical necessity. See "Compliance Information" on back.

ThinPrep COLLECT DATE AND TIME: \_\_\_\_/\_\_\_\_/\_\_\_\_ : \_\_\_\_ ONE

Source: (Check one)  Vaginal  Cervical/Endocervical  Anal

LMP \_\_\_\_/\_\_\_\_/\_\_\_\_

Pregnant?  Yes  No  Contraceptive Use?  Yes  No  Post Partum?  Yes  No  Hormone Use?  Yes  No

GYN Clinical and Treatment History: \_\_\_\_\_

**SPECIMEN INFORMATION**

Collect Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Collect Time: \_\_\_\_:\_\_\_\_ Fasting  Yes  No Fax to # \_\_\_\_\_ Phone to # \_\_\_\_\_

24 Hour Urine Volume: \_\_\_\_\_

PANELS Panel info on back		Blood	Urine	Other	MICROBIOLOGY	
BMP	Basic Metabolic Panel	T			Culture and Gram Smear* Culture & Gram Smear, W/Susceptibilities If Indicated	
CMP	Comprehensive Metabolic Panel	T			CTGC	Chlam/GC
LYT	Electrolytes Panel	T			LAB17623	Anaplasma/Babesia PCR L
LPR	Lipid Panel	T			LAB17401	Molecular Vaginitis/Vaginosis Detection Or
LIVR	Hepatic Panel	T			LAB14319	Clinic-Collect COVID-19 MY
PNAT	Prenatal Panel Bb,L,R,√ EDC: _____ Transf. Hx: _____				SXBBD	Group B Strep, PCR SW
THCAS	Thyroid Cascade	T			LAB14535	Group A Strep, PCR SW
ANECAS	Anemia Cascade L, T				IOFLUR	Influenza / RSV, PCR X
<b>CHEMISTRY</b>					HSVLUM	Herpes Simplex, PCR X
ALB	Albumin	T			VZVLUM	Varicella-zoster, PCR X
ALPK	Alkaline Phosphatase	T			<b>HEMATOLOGY</b>	
ALT	ALT	T			CBC	CBC
AMY	Amylase	T			CBCDF	CBC with Diff L
ANAIFA	(ANA) Anti Nuclear Ab, IFA	T			HGB	Hemoglobin L
ANCAIF	(ANCA) Anti Neutrophil Ab IFA	T			HCT	Hematocrit L
AST	AST	T			PRO	Prothrombin Time (includes INR) on Coumadin? Y or N B φ
DBIL	Bilirubin Direct/Indirect	T			PTT	PTT B φ
CDP	Celiac Disease Panel	T			RET	Reticulocyte Count L
CRPP	C-Reactive Protein	T			SWE	Sed. Rate, Westergren L
CA125T	Cancer Antigen 125	T			<b>FECAL TESTS</b>	
CA	Calcium, Total	T			CDIFBD	C. Difficile, PCR U
CEA	CEA	T			FECBD	Fecal Bacterial Pathogen X
CHOL	Cholesterol, Total	T			FELF	Fecal Lactoferrin for WBC U
CK	CK	T			GICR	Giardia/Cryptosporidium Ag Op
DNA	Anti dsDNA	T			HPSA	H.pylori Fecal Ag U
BUN	Blood Urea Nitrogen	T			OCCB	Occult Blood, Feces, Diagnostic X
CREAT	Creatinine	T			OP	Ova and Parasite Op
SERPEP	Electrophoresis, Serum	T			<b>URINALYSIS</b>	
FER	Ferritin	T			LAB14587	UA Cascade to Culture U
SERFLC	Free Light Chains, Serum	T			LAB239	Urine Culture Only U
FSH	FSH	T			LAB348	UA Chem + Sed (no reflex) U
GGT	GGT	T			LAB3695	UA Chem Only U
SGL	Glucose	T				
GT1	Glucose, 1 Hr Gestational Screen	X				
HCGS	HCG Pregnancy	T				
HCGTUM	HCG Non Pregnancy	T				
HDL	HDL Cholesterol	T				
HAABN	Hepatitis A Total, Ab	T				
HAAB2	Hepatitis A Tot. Ab W/ Reflex	T				
HBABQ2	Hepatitis B Ab (Surface)	T				
HBSAG	Hepatitis B Antigen (Surface)	T				
HBCOR	Hepatitis B Core Ab	T				
HCSOR2	Hep C Ab w/Reflex PCR	T				
HA1C	Hemoglobin A1C	L				
<b>URINE CHEMISTRY</b>						
		LAB743	Urine Albumin to Creatinine Ratio	U		
		LAB3650	Urine Protein to Creatinine Ratio	U		
		LAB3740	Urine Drug Screen (Polysubstance)	U		

Must have at least 2 patient identifiers on each patient sample

Test Information Website  
UVM Labs.TestCatalog.org

For specimen and container info see back of form

IF YOU WISH TO DECLINE REFLEX INDICATE TESTS HERE

DATE \_\_\_\_\_ TIME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ \*PROVIDER SIGNATURE