University of Kentucky Hospital

Chandler Medical Center - Lexington, KY

PHYSICIAN ORDER FORM

LAB 1

PATIENT ID:

Date/Time of Collection:

Accession #:

Medical Record #

Collector:

LCRA label by:

Date of Birth

M F

R	CODE	S	HEMATOLOGY
	HEM		HEMOGRAM
	HEMD		HEMOGRAM W/DIFF
	PLTC		PLATELET COUNT
	HBG		HEMOGLOBIN
	HCT		HEMATOCRIT
	HCTSPN		HCT, SPUN
	WBC		WBC COUNT
	MDIF		MANUAL SLIDE REVIEW
	BANDCT		BAND COUNT
	ESRW		SED RATE, WESTERGREN
	RETC		RETICULOCYTE COUNT
	ANA		ANTI-NUCLEAR Ab
			HEMOSTASIS
	PT		PROTIME
	PTT		APTT
	XDP		D-DIMER
	CFGN		FIBRINOGEN
	PFA		PLAT FUNC ANALYSIS
	TCT		THROMBIN CLOT TIME
			SEROLOGY
	HEP		ACUTE HEPATITIS PANEL
	HAM		HEPATITIS A IgM
	HAG		HEPATITIS A IgG & IgM
	HBEB		HEPATITIS Be Ab
	HBSAG		HEP B SURFACE ANTIGEN
	HBSAB		HEPATITIS B SURFACE Ab
	HBCM		HEPATITIS B CORE IgM
	HBCAB		HEPATITIS B CORE IgG & IgM
	HEC		HEPATITIS C Ab
	HIV		HIV I/II Ab
	MSPT		MONOSPOT
	RPR		RAPID PLASMA REAGIN
	RUB		RUBELLA TITER IgG
	CD48		T4T8 ENUMERATION
			DRUG LEVELS
	CRBZ		CARBAMAZEPINE
	CSA		CYCLOSPORINE
	DIG		DIGOXIN
	LAMOT		LAMOTRIGINE
	PHNO		PHENOBARBITAL
	PHTN		PHENYTOIN
	SIRO		SIROLIMUS
	TACRO		TACROLIMUS
	VALP		VALPROIC ACID

R	CODE	S	CHEMISTRY
	ALB		ALBUMIN
	ALCO		ALCOHOLS
	ALP		ALK. PHOSPHATASE
	ALT		ALT
	on ice		AMMONIA
	AMY		AMYLASE
	TPO		ANTITHYROID PEROXIDASE Ab
	AST		AST
	CBIL		BILIRUBIN, CONJUGATED
	TBIL		BILIRUBIN, TOTAL
	BNP		B-NATRIURETIC PEPTIDE
	CRP		C REACTIVE PROTEIN
	CRPH		HIGH SENSITIVITY CRP
	CA		CALCIUM
	ICA		CALCIUM, IONIZED
	CL		CHLORIDE
	MBCK		CK MB
	CK		CK, TOTAL
	CO2		CO2
	CORTS		CORTISOL AM or PM
	CREA		CREATININE
	FOLS		FOLATE, SERUM
	FSH		FOLLICLE STIM HORMONE
	GGT		GAMMA GT
	GLU		GLUCOSE
	HCG		HCG, TOTAL BETA
	HA1C		HEMOGLOBIN A1C
	on ice		HOMOCYSTINE
	FE		IRON
	TIBC		IRON BINDING WITH TOTAL IRON
	TRNF		TRANSFERRIN
	(may order TIBC or TRANSFERRIN, but not both)		
	FER		FERRITIN
	KETN		KETONES, QUAL
	on ice		LACTIC ACID
	LDH		LDH, TOTAL
	LPSE		LIPASE
	LI		LITHIUM
			PSA DIAGNOSTIC AND SCREENING
	PSASC		SCREENING PSA
	PSA		DIAGNOSTIC PSA
	FPSA		FREE PSA (INCLUDES TOTAL)

R	CODE	S	CHEMISTRY
	LH		LUTEINIZING HORMONE
	MG		MAGNESIUM
	OSMO		OSMOLALITY
	PHOS		PHOSPHORUS
	K		POTASSIUM
	PALB		PREALBUIMN
	PROL		PROLACTIN
	TP		PROTEIN, TOTAL
	RA		RHEUMATOID FACTOR
	NA		SODIUM
	T3		T3, TOTAL
	FT4I		T4, FREE
	CTNI		TROPONIN I
	TSH		TSH
	BUN		UREA NITROGEN
	URIC		URIC ACID
	VB12		VITAMIN B12
			URINE TEST
	UA		URINALYSIS
	PREG		PREGNANCY, QUAL
	XUA		URINE DIPSTICK ONLY
			PANELS & ORDER PACKAGES
	P1		ELECTROLYTE PANEL
	P2		BASIC METABOLIC PANEL
	P6		MODIFIED RENAL FUNCTION PKG Includes: BUN, CL, CA, K, NA, CO2, PHOS, ALBUMIN, CREATININE
	P5		RENAL FUNCTION PANEL
	P7		HYPERTENSION PKG Includes: BUN, CL, CA, K, NA, CO2, CREAT
	P3		HEPATIC FUNCTION PANEL
	P4		COMPREHENSIVE PANEL
	OBP		PRE-ECLAMPSIA PANEL
	TPN1		TPN 1- NICU
	TPN2		TPN 2- NICU
	TOP1		THYROID ONCOLOGY 1 **3 gold**
	TOP2		THYROID ONCOLOGY 2 **1 green and 3 gold**
	PTHP1		PARATHYROID PANEL 1 **2purple + 1green ice**
	PTHP2		PARATHYROID PANEL 2 **2purple + 1green ice**

Annual screening exam

Patient is exhibiting symptoms requiring this test Describe:

ADDITIONAL TESTS			FIRST YR		SUBSQ YEARS
	LIPID	LIPID PANEL	ONCE	LIPID PANEL	ONCE
	CHOL	CHOLESTEROL		CHOLESTEROL	THREE
	HDL	HDL CHOL W/TOTAL	SIX*	HDL CHOL W/TOTAL	
	TRIG	TRIGLYCERIDES		TRIGLYCERIDES	

*ANY COMBINATION, BUT ONE TEST AT A TIME

REASON FOR EXAM

Reason for exam/signs or symptoms (List pertinent history and specific symptoms for each test.) The following are not acceptable: "r/o, suspected, pre-op".

Ordering Physician Signature: _____ ID #: _____ Date: _____ Time: _____

TO BE COMPLETED BY CLINIC CHECK-OUT STAFF *IF REQUESTING PHYSICIAN IS A RESIDENT, ATTENDING PHYSICIAN INFORMATION IS REQUIRED*

	Requesting Physician	Attending Physician	Pager #	Telephone #
Full Name				

Primary Insurance _____ Secondary Insurance _____

If patient is covered by Medicare AND a highlighted test is ordered:

1) Has medical necessity check been completed for Medicare Part A? Y I NA

2) Has medical necessity check been completed for Medicare Part B? Y N

3) ABN: ___ Required ___ Discussed ___ Signed

ICD-9-CM CODES

(REQUIRED)

Clinic Staff Signature _____ Service: _____ Phone Number _____ Date _____