

University of Kentucky Hospital Chandler Medical Center - Lexington, KY		PHYSICIAN ORDER FORM LAB 7		PATIENT ID: _____			
Date and Time of Collection: _____		Accession #: _____		Patient Name: _____			
Collector: _____		LCRA label by: _____		Med Rec #: _____			
				Date of Birth: _____ M F			
FUNGAL SEROLOGY		REASON		MISCELLANEOUS SEROLOGY		REASON	
<input type="checkbox"/>	WILD	COCCIDIOIDES TITER		<input type="checkbox"/>	EBVG	EPSTEIN BARR VCA IgG	
<input type="checkbox"/>	WILD	FARMER'S LUNG		<input type="checkbox"/>	EBVM	EPSTEIN BARR VCA IgM	
<input type="checkbox"/>	FUCTID	FUNGAL PROFILE		<input type="checkbox"/>	2 GOLD	EPSTEIN BARR PANEL	
SYPHILIS SEROLOGY				<input type="checkbox"/>	HPYLOR	HELICOBACTER PYLORI ANTIBODY	
<input type="checkbox"/>	RPR	RAPID PLASMA REAGIN		<input type="checkbox"/>	HIV	HIV I-II ANTIBODY	
FEBRILE SEROLOGY				<input type="checkbox"/>	P24	HIV ANTIGEN P24	
<input type="checkbox"/>	WILD	FEBRILE AGGLUTININ PANEL		<input type="checkbox"/>	HTLV	HTLV-I ANTIBODY	
<input type="checkbox"/>	BRUC	BRUCELLA		<input type="checkbox"/>	WILD	INFLUENZA A ANTIBODY	
<input type="checkbox"/>	WILD	RICKETTSIAL AGGLUTININS		<input type="checkbox"/>	INFLNB	INFLUENZA B ANTIBODY	
<input type="checkbox"/>	RMSF	ROCKY MT. SPOTTED FEVER IgG		<input type="checkbox"/>	LCM	LCM TITER	
<input type="checkbox"/>	RMSFM	ROCKY MT. SPOTTED FEVER IgM		<input type="checkbox"/>	LEGNLA	LEGIONELLA TITER IgG	
<input type="checkbox"/>	TUL	TULAREMIA		<input type="checkbox"/>	LEGIGM	LEGIONELLA TITER IgM	
TORCH ANTIBODIES				<input type="checkbox"/>	LEISHM	LEISHMANIASIS ANTIBODY	
<input type="checkbox"/>	CMVG	CMV-IgG		<input type="checkbox"/>	LEPA	LEPTOSPIRA AGGLUTININS	
<input type="checkbox"/>	CMVM	CMV-IgM		<input type="checkbox"/>	LYME	LYME DISEASE ANTIBODY	
<input type="checkbox"/>	HSV	HERPES IgG		<input type="checkbox"/>	LGV	LYMPHOGRANULOMA VENEREUM TITER	
<input type="checkbox"/>	HIGM	HERPES IgM		<input type="checkbox"/>	MUMPS	MUMPS IgG & IgM	
<input type="checkbox"/>	HSV6	HERPES SIX ANTIBODY		<input type="checkbox"/>	MYP	MYCOPLASMA TITER	
<input type="checkbox"/>	RUB	RUBELLA IgG		<input type="checkbox"/>	PAFLU	PARAINFLUENZA	
<input type="checkbox"/>	RUBM	RUBELLA IgM		<input type="checkbox"/>	PARVO	PARVOVIRUS ANTIBODIES	
<input type="checkbox"/>	TOXOG	TOXOPLASMA IgG		<input type="checkbox"/>	PVB19G	PARVOVIRUS B19, IgG	
<input type="checkbox"/>	TOXOM	TOXOPLASMA IgM		<input type="checkbox"/>	PVB19M	PARVOVIRUS B19, IgM	
STREPTOCOCCAL SEROLOGY				<input type="checkbox"/>	PNEUMO	PNEUMOCOCCAL VACCINE IgG RESPONSE	
<input type="checkbox"/>	ASO	ASO TITER		<input type="checkbox"/>	POLIO1P	POLIO 1, 2, 3, TITERS	
MISCELLANEOUS SEROLOGY				<input type="checkbox"/>	WILD	PSITTACOSIS TITER	
<input type="checkbox"/>	WILD	ADENOVIRUS TITER		<input type="checkbox"/>	Q	Q FEVER	
<input type="checkbox"/>	AMEB	AMEBIASIS TITER		<input type="checkbox"/>	RABIES	RABIES TITER	
<input type="checkbox"/>	WILD	ARBOVIRUS TITER		<input type="checkbox"/>	RSVT	RSV TITER	
<input type="checkbox"/>	BARTGM	CAT SCRATCH FEVER, B.HENSELAE		<input type="checkbox"/>	RUBEO	RUBEOLA IgG ANTIBODY	
<input type="checkbox"/>	CHLAMT	CHLAMYDIA TITER		<input type="checkbox"/>	RUBEOM	RUBEOLA IgM ANTIBODY	
<input type="checkbox"/>	COLD	COLD AGGLUTININS		<input type="checkbox"/>	TEICAD	TEICHOIC ACID ANTIBODY	
<input type="checkbox"/>	COXB	COXSACKIE B VIRUS		<input type="checkbox"/>	TETNUS	TETANUS ANTIBODY TITER	
<input type="checkbox"/>	CYSTI	CYSTICERCOSIS ANTIBODY		<input type="checkbox"/>	TRICHS	TRICHINOSIS ANTIBODY	
<input type="checkbox"/>	DIPH	DIPHtheria ANTIBODY		<input type="checkbox"/>	TOXCAR	TOXOCARA TITER	
<input type="checkbox"/>	ECHINO	ECHINOCOCCUS ANTIBODY		<input type="checkbox"/>	VAR	VARICELLA IgG ANTIBODY	
<input type="checkbox"/>	ECHO	ECHO TITER		<input type="checkbox"/>	VARM	VARICELLA IgM ANTIBODY	

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 _____	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 N 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 _____
 J349 2-20-04 /10-11-07 White - Clinic Chart Yellow - Laboratory Pink - Medical Records