

Department of Pathology

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Glens Falls Hospital

An affiliate of ALBANY MED

Collection Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_
LT BLUE: \_\_\_ SST: \_\_\_ PLAIN RED: \_\_\_
Li Hep: \_\_\_ EDTA: \_\_\_ ROYAL BLUE: \_\_\_
GRAY: \_\_\_ SWAB: \_\_\_ Fasting Status: \_\_\_
STOOL: \_\_\_ URINE: \_\_\_ [ ] NO [ ] YES [ ] STAT
PRIORITY: [ ] ROUTINE [ ] STAT

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial): \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_
Social Security Number: \_\_\_-\_\_\_-\_\_\_ Gender: \_\_\_ Race: \_\_\_ Ethnicity: \_\_\_
Address: \_\_\_ Phone: ( ) \_\_\_

BILLING INFORMATION

ORDERING PROVIDER

Insurance: \_\_\_
Subscriber ID: \_\_\_ Group Number: \_\_\_
Address: \_\_\_
City/State/ZIP: \_\_\_
Phone: ( ) \_\_\_ Subscriber DOB: \_\_\_
Subscriber Name/Relationship: \_\_\_

Ordering Clinician Name & Credentials (LEGIBLY PRINTED)

Phone: ( ) \_\_\_ Fax: ( ) \_\_\_

Ordering Clinician Signature (REQUIRED)

Date

ICD-10 DIAGNOSIS CODE & ADVANCE BENEFICIARY NOTICE (ABN)

MEDICAL NECESSITY REGULATIONS: At the government's request, the laboratory would like to remind all physicians that when ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, when certain laboratory tests are ordered and the frequency and/or diagnosis is not considered "reasonable and necessary" under the National and/or Local Coverage Determinations, payment may be denied. Medicare requires an ABN be reviewed with and signed by the patient.

[ ] ABN not required [ ] Patient has signed ABN Waiver [ ] Patient refused to sign ABN Waiver

ICD-10 Diagnosis Code(s) (REQUIRED):

The ICD-10 codes provided below as a reference. The most specific and appropriate code(s) applicable to the patient and the test(s) being ordered must be written in the space provided above.

- [ ] R10.9 - Abdominal pain, NOS [ ] R30.0 - Dysuria [ ] E03.9 - Hypothyroidism, NOS [ ] I73.9 - Peripheral vascular disease, NOS
[ ] I48.91 - Atrial fibrillation, NOS [ ] I10 - Essential (primary) hypertension [ ] D50.9 - Iron deficiency anemia, NOS [ ] Z12.5 - Screening for malignant neoplasm of prostate
[ ] D64.9 - Anemia, NOS [ ] I50.9 - Heart failure, NOS [ ] Z79.01 - Long term (current) use of anticoagulant [ ] E11.9 - Type 2 DM w/o complications
[ ] N18.9 - Chronic kidney disease, NOS [ ] R31.9 - Hematuria, NOS [ ] R73.09 - Other abnormal glucose [ ] E53.8 - Deficiency of other specified B group vitamins
[ ] K74.60 - Cirrhosis of liver, NOS [ ] E78.5 - Hyperlipidemia, NOS [ ] R53.83 - Other fatigue [ ] E55.9 - Vitamin D deficiency, NOS

GENERAL LABORATORY TESTS PERFORMED AT GFH

ABN requirement for tests with \* and bold

THERAPUTIC DRUG MONITORING

- [ ] Basic Metabolic Panel (BMP) PN0002306 (BUN, Calcium, Creatinine, Electrolytes, Glucose)
[ ] Comprehensive Metabolic Panel (CMP) PN0002307 (BMP + Albumin, ALP, ALT, AST, T-Bili, Total Protein)
[ ] Electrolyte Panel PN0002308 (CO2, Cl-, K+, Na+)
[ ] Hepatic Function Profile PN0002310 (Albumin, ALP, ALT, AST, Direct Bili, Total Bili, Total Protein)
[ ] Hepatitis Acute Panel \* PN0002305 (Hep A IgM Ratio, Hep B Surface Ag, Hep B Core Ab IgM, Hep C Virus)
[ ] Lipid Panel \* PN0002311 (Cholesterol, HDL, LDL, Triglycerides)
[ ] OB/Prenatal Panel w/o HIV Scm PN0002312 (ABO/Rh, Ab Screen, CBC w/auto diff, Hep B Surface Ag, Rubella IgG, Syphilis IgG/M)
[ ] OB/Prenatal Panel WITH HIV Scm PN0012221 (same as above + HIV Scm (4th Gen) Rfx 1/2 Ab)
[ ] Renal Function Panel PN0002313 (Albumin, BUN, Calcium, Creatinine, Electrolytes, Glucose, Phosphorus)
[ ] Amylase PN0002325
[ ] APTT \* PN0002345
[ ] Bilirubin, Direct PN0002416
[ ] Bilirubin, Total PN0002417
[ ] Blood Urea Nitrogen (BUN) PN0003240
[ ] Calcium PN0002446
[ ] CBC w/ auto diff \* PN0003357
[ ] CBC w/ manual diff \* PN0003358
[ ] Cholesterol \* PN0002483
[ ] Creatine Kinase (CK) PN0002494
[ ] Creatinine PN0002528
[ ] Cortisol PN0002516
[ ] C-Reactive Protein (CRP) PN0002522

- [ ] Sodium PN0003102
[ ] Syphilis IgG/IgM PN0009013
[ ] T3, Total \* PN0003177
[ ] T4, Total \* PN0003179
[ ] T4 Free (Direct) \* PN0003178
[ ] Testosterone, Total PN0003185
[ ] TIBC \* (includes iron) PN0003212
[ ] Triglycerides \* PN0003226
[ ] TSH, Sensitive \* PN0003233
[ ] TSH with reflex to T4 Free \* PN0012414
[ ] Uric Acid PN0003247
[ ] Vitamin B12 PN0003273
[ ] Vitamin D 25 OH PN0003277

- URINE
Please indicate random or 24hr
[ ] Calcium [ ] Random [ ] 24 Hr
[ ] Creatinine [ ] Random [ ] 24 Hr
[ ] Creatinine Clearance [ ] Random [ ] 24 Hr
REQUIRED HT: \_\_\_ WT: \_\_\_
[ ] Electrolytes (Cl-, K+, Na+) [ ] Random [ ] 24 Hr
[ ] Pregnancy Screen PN0003009
[ ] Urinalysis \* PN0003429
SOURCE: \_\_\_
[ ] Urinalysis w/Rfx to culture \* PN0011928
SOURCE: \_\_\_

- TUMOR MARKERS
[ ] Alpha Feto Protein (AFP) \* PN0009056
[ ] CEA \* PN0002464
[ ] CA 125 \* PN0002434
[ ] CA 15-3 \* PN0002435

- BLOOD BANK
[ ] ABO/Rh PN0003361
[ ] Ab Screen PN0003362
[ ] Type & Screen (ABO/Rh & Ab Screen)

- [ ] Gentamicin Level PN0002668
[ ] Digoxin (Lanoxin) \* PN0002567
[ ] Dilantin PN0002568
[ ] Phenobarbital PN0002978
[ ] Lithium PN0002882
[ ] Valproic Acid PN0003257
[ ] Vancomycin PN0003259

MICROBIOLOGY

- \*\* = MUST indicate specimen site/source below
[ ] Blood Culture PN0002421
[ ] Body Fluid / CSF Culture \*\* PN0003160
[ ] Clostridium difficile by PCR PN0003525
[ ] Cryptococcal Ag [ ] Blood [ ] CSF PN0002534
[ ] FIT Testing-Stool
[ ] Fungal Culture \*\*
[ ] Genital Culture - FEMALE \*\* PN0003254
[ ] Genital Culture - MALE \*\* PN0003255
[ ] Giardia/Crypto Screen, Stool (Ova & Parasite Screen) PN0003423
[ ] Legionella Urine Ag PN0012206
[ ] MRSA - Nares, PCR PN0011923
[ ] RSV \*\* PN0003066
[ ] Shiga Toxin 1 & 2 PN0004500
[ ] Stool Culture PN0003163
[ ] Strep A by PCR PN0009011
[ ] Strep B by PCR PN0009012
[ ] Trichomonas (rapid) PN0006484
[ ] Tissue / Aspirate Culture \*\* PN0002352
[ ] Upper Respiratory Culture \*\* PN0003237
[ ] Urine Culture \*\* PN0003251
[ ] Wound Culture SURGICAL \*\* PN0003173
[ ] Wound Culture NON-SURGICAL \*\* PN0002536

\*\*Site / Source: \_\_\_

\*\*SEE REVERSE FOR MORE INFORMATION & TESTING\*\*

**PATIENT INFORMATION** \*\*Insurance, complete patient & ordering provider information MUST be completed on other side. \*\*

**Patient Name (Last, First, Middle Initial):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATHOLOGY** \*ALL fields under applicable category REQUIRED \*

**CYTOLOGY / SURGICAL**

Surgical Excision / Biopsy?       NO       YES

Cytology non-gynecologic specimen?       NO       YES

Specimen source name: (Please include side / lobe / upper / lower as applicable)

\_\_\_\_\_  
 \_\_\_\_\_

Any ancillary tests that should be performed on this specimen:

\_\_\_\_\_  
 \_\_\_\_\_

Clinical history / reason for specimen procedure:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please indicate ALL Clinicians / Oncologists that should receive a copy of the associated reports :

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAP SMEAR**

Source?       Endocervical       Cervical       Vaginal

Pregnant?       NO       YES

Postpartum?       NO       YES

Postmenopausal?       NO       YES

Hysterectomy?       NO       YES

Pap Smear Order:

Pap REFLEX HPV (will reflex to HPV only if diagnosis is ASCUS)

Pap w/ HPV

Pap w/ HPV & CT/NG

Pap w/ HPV & CT/NG & Trichomonas

Clinical Information:

Last Menstrual Period Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relevant Patient History:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Continued from front - OTHER TESTS/SPECIAL INSTRUCTIONS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_