

Requisitions, Consent Forms and Billing Information

Client Requisition



UnityPoint Health
36 S. Brooks Street
Madison, WI 53715
(800) 236-0465
(608) 417-6529

A 275001

LABORATORY REQUISITION

PLEASE PRINT

ACCT. NO.
 Routine Call Back To: Phone # _____
OR
 STAT Fax To: Fax # _____

Phleb: Patient Last Name First M.I.
TRIP
DRAW
Rt. Arm
Lt. Arm
Rt. Hand
Lt. Hand
Other:
Nurse Collect

Bill To: ACCOUNT/FACILITY (CPAY) PATIENT/THIRD PARTY (INSURANCE) (BILL)

Sex Race Species Date Of Birth -- --

ORDERING PROVIDER LAST NAME FIRST NAME

COLLECTION DATE COLLECTION TIME A.M. P.M. PT. CLINIC NO. OR ROOM NO.

NOTE: "BILL TO" MUST BE CHECKED AT TIME OF COLLECTION. IF NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED
Label affixed to Part 1

Billing Information - Complete Only For Patient/Third Party

RELATION OF PATIENT TO RESPONSIBLE PARTY: SELF SPOUSE DEPENDENT OTHER INSURANCE COMPANY

DIAGNOSIS CODE (ICD-9/10): INDICATE ICD-9 OR ICD-10 FOR EACH TEST ORDERED. THE PHYSICIAN MUST INDICATE ALL TESTS ORDERED TO BE MEDICALLY NECESSARY. ADDRESS

NAME OF RESPONSIBLE PARTY LAST FIRST M.I. CITY, STATE, ZIP GROUP/FILE NO.

BILL TO ADDRESS POLICY/SUBSCRIBER NO.

CITY, STATE, ZIP PHONE NO. MEDICARE NO. MEDICAID NO.

Indicate (X) Specimen Type Fasting Non-Fasting Signed ABN on file at MD's office or ordering facility?
 Serum - SST Plasma-Li Heparin Urine-random CSF YES NO
 Serum-red top Plasma-Na Citrate Urine - 24 hr _____ mL Other _____ **ABN collected at ML?** YES NO
 Plasma-EDTA Urine-timed _____ hrs

A275001 ACCT. NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT. NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

A275001 ACCT. NO. _____ DATE _____
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LAST NAME FIRST
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TESTS

A275001 ACCT. NO. _____ DATE _____
LAST NAME FIRST
TESTS
TESTS

Face Part 1 - 12" x 11" - vertical perf at 0.5" and 9.5" from the left

Apply labels to specimens and remove this portion

IMPORTANT INSTRUCTIONS
WHEN CHECKING BOXES, PLEASE USE AN "X" RATHER THAN A ✓ OR A SLASH.
I.E. = AMYLASE

Patient Glucose Meter/Laboratory Correlation

UnityPoint-Meriter Laboratories
36 S. Brooks St.
Madison WI 53715

Patient Information:
(chip or Lab label)

Patient Glucose Meter/Laboratory Correlation

Instructions for Clinic/Floor:

1. Order Epic test **492073**.
2. **Patient should not have eaten, dosed or been given insulin within 2 hours of this test being performed.**
3. Inpatient orders will be drawn by Inpatient Phlebotomy in the patient’s room.
4. All other patients should be sent to 2 Center Lab with an OB chart label for patient identification.

Instructions for Phlebotomy staff:

1. LIS will print two labels for “GLMTR” test. Phlebotomy staff will then fill out a Glucose Meter Correlation Sheet and attach one of the SOFT labels to the area in the upper right hand corner of the form.
2. Collect one Lithium Heparin plasma blood specimen.
3. Direct the patient to immediately (within 5 minutes of lab draw) perform a glucose test using their **personal** blood glucose meter.
4. Fill in the patient fingerstick glucose result from their **personal** blood glucose meter on the form while still with the patient.
5. Mark test as collected in the lab computer.
6. Send the Lithium Heparin tube along with this paperwork to the laboratory

Test Information: (Phlebotomist staff- fill out)

ML Order Number: _____(or put on small sticker of lab label)

Collection Date: _____

Collection Time: _____

****Patients Meter Result:** _____