REVISED FORM — UPDATED 03/2021

COMMAND LAB FORMS 800-570-8755 EXT. 4

112793

CLIENT INFORMATION

ACCESSION NUMBER
PLACE LABEL HERE

6103 Strickland Ave. Suite D, Brooklyn, NY 11234
Tel: 1-888-826-3349 (1-888-8-AMEDiX)
Fax: 1-888-826-3349 AmedixLaboratory.com

# GENERAL TEST REQUISITION

## Patient Information *(Required)*

**Name** (Last, First, M)_____
Address _____
City, State, Zip _____
Phone# _____
**Date of Birth** ____/____/____ Patient SSN _____
Gender [ ] M [ ] F Client Chart/Pt. ID# _____

**Order Date** ____/____/____ ☐ STAT ☐ Fasting _____ hrs.
**Collection Date** ____/____/____ **Time of Collection** _____:_____ AM PM
**Collector Name** _____

☐ Fax Report to _____ ☐ Call Results to_____

**MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)**
I have read the ABN on the reverse. If Medicare denies payment, I agree to pay for the identified test(s).

X_____
Patient's Signature Date

## INSURANCE INFORMATION *A clear copy of insurance card(s) front and back is required.*

[ ] Self [ ] Spouse [ ] Child [ ] Other
**Insurance Name** _____
**Insurance ID#** _____
**Group#/Category #** _____
**Insured Name** (If different than patient) _____
**Insurance Address** _____
**Insurance City, State, Zip** _____
**Insurance Telephone #** _____
**BILL TO** [ ] Patient [ ] Client [ ] Medicare [ ] Medicaid [ ] Insurance [ ] Other

**DX Codes** *(Required)* **List all ICD10 codes:**
[ ]_____ , [ ]_____ , [ ]_____ , [ ]_____
[ ]_____ , [ ]_____ , [ ]_____ , [ ]_____

**Doctor's Signature** *(Required)*

## COMMON PANELS

| | | | |
|---|---|---|---|
| 1120 ☐ **BASIC METABOLIC** SS<br>Na, K, Cl, CO2, Creat, Ca, Gluc, BUN | 1130 ☐ **COMPREHENSIVE METABOLIC** SS<br>Na, K, Cl, CO2, Ca, Creat, Gluc, Tot. Prot., Alb, BUN, ALP, AST, ALT, Tot. Bili | 1140 ☐ **HEPATIC FUNCTION** SS<br>ALB, Tot. Prot., Tot. Bili., ALP, AST, ALT | 1150 ☐ **LIPID** SS<br>CHOL, HDL, LDLc, TRIG, vLDLc |
| 3075 ☐ **THYROID** SS<br>T4, TU, TSH, T3 free, T3 tot. | 850 ☐ **IRON DEFICIENCY** SS<br>Iron, TIBC, UIBC, % Sat, Ferritin, Transferrin | 840 ☐ **ARTHRITIS** LV, SS<br>CBC, ANA, ASO, ESR, RF, UA, CCP IgG Ab | 1180 ☐ **ANEMIA** LV, SS<br>CBC, Iron, TIBC, UIBC, Retic. Ct., Ferritin, vitB12, FOL, Transferrin |

| HEMATOLOGY | | ALPHABETICAL TESTS | | | | | |
|---|---|---|---|---|---|---|---|
| 372 ☐ BNP | LV | B036 ☐ ABO group & Rh | PNK | 800 ☐ DHEA | SS | 304 ☐ RF | SS |
| 20 ☐ CBC w/ Diff. | LV | 197 ☐ AFP | SS | 185 ☐ Estradiol | SS | 432 ☐ Rubella IgG Ab | SS |
| 371 ☐ D-Dimer | LV | 101 ☐ ALB | SS | 115 ☐ Ferritin | SS | 305 ☐ RPR | SS |
| 246 ☐ ESR | LV | 102 ☐ ALP | SS | 163 ☐ Folate | SS | 133 ☐ Sodium | SS |
| 036 ☐ PT/INR | BL | 106 ☐ ALT | SS | 029 ☐ Fructosamine | SS | 145 ☐ T3 uptake | SS |
| 037 ☐ PTT | BL | 712 ☐ Ammonia | LV | 139 ☐ FSH | SS | 023 ☐ T3 free | SS |
| 247 ☐ Reticulocyte count | LV | 105 ☐ Amylase | SS | 116 ☐ GTP (GGT) | SS | 980 ☐ T3 tot | SS |
| | | 301 ☐ ANA Screen w/rflx | SS | 118 ☐ Globulin | SS | 144 ☐ T4 | SS |
| | | H535 ☐ Anti-Thyroglobulin Ab | SS | 117 ☐ Gluc. (fasting) | GY | 252 ☐ T4 free | SS |
| | | 302 ☐ ASO | SS | 119 ☐ Glyco ( HbA1c) | LV | 197 ☐ Theophylline | SS |
| | | 107 ☐ AST | SS | 463 ☐ bHCG (Qty) | SS | H103 ☐ Thyroglobulin Ab | SS |
| | | 113 ☐ Bilirubin Direct | SS | 147 ☐ HCG ( Qual) | SS | B033 ☐ Thyroglobulin | SS |
| | | 129 ☐ Bilirubin Total | SS | 108 ☐ HDL | SS | H497 ☐ Thyroid Peroxidase Ab | SS |
| | | 678A ☐ pBN P | SS | 324 ☐ Hep A tot Ab | SS | 121 ☐ TIBC | SS |
| | | 136 ☐ BUN | SS | 320 ☐ Hep B Surf Ab | SS | 187 ☐ Testosterone | SS |
| | | 664 ☐ C3 | SS | 319 ☐ Hep B Surf Ag | SS | 131 ☐ Total Protein | SS |
| | | 665 ☐ C4 | SS | B015 ☐ Hep B Core Ab | SS | 146 ☐ TSH | SS |
| | | 103 ☐ Calcium | SS | 971 ☐ Hep C Vir Ab | SS | 231 ☐ Transferrin | SS |
| | | 684 ☐ CA125 | SS | 316 ☐ Herpes I and II IgG | SS | 132 ☐ Triglycerides | SS |
| | | 698 ☐ CA15.3 | SS | 5067 ☐ HIV ½ Ab, p24 Ag* | SS | 531 ☐ Troponin I | GN |
| | | 685 ☐ CA19.9 | SS | 677 ☐ Homocysteine | SS | 0121 ☐ UIBC | SS |
| | | 025 ☐ CA 27.29 | SS | B017 ☐ H.Pylori Ab IgG | SS | 137 ☐ Uric Acid | SS |
| | | B10 ☐ Carbamazepine | SS | 580 ☐ Human Growth Hormone | SS | NGYN ☐ Urine Cytology | UR |
| | | 383 ☐ CEA | SS | 2924 ☐ HPV | OT | 1448 ☐ Urine Drug Screen | UR |
| | | 135 ☐ Chloride | SS | 386 ☐ Insulin | SS | 212 ☐ Urine Microalbumin | UR |
| | | 109 ☐ Cholesterol, Total | SS | 120 ☐ Iron | SS | 310 ☐ Urine Pregnancy | UR |
| | | 130 ☐ CO2 | SS | 123 ☐ LDH | SS | 962 ☐ Valproic Acid | RE |
| | | 495 ☐ COR | SS | 198 ☐ LDL | SS | 356 ☐ Vancomycin | RE |
| | | 110 ☐ CPK | SS | 140 ☐ LH | SS | 075 ☐ Varicella Ab | SS |
| | | 111 ☐ CKMB | SS | 124 ☐ Lipase | SS | 162 ☐ Vit. B12 | SS |
| | | 112 ☐ Creatinine | SS | 709 ☐ Lithium | RE | 160 ☐ Vit.D, 25-Hydroxy | SS |
| | | 300 ☐ CRP | SS | 125 ☐ Magnesium | SS | **URINALYSIS** | |
| | | 1537 ☐ hsCRP | SS | 0944 ☐ Measles Ab IgG | SS | 030 ☐ Urinalysis w/ microscopic | UR |
| | | 714 ☐ C-Pep | SS | 765 ☐ Mumps Ab IgG | SS | **MICROBIOLOGY** | |
| | | 148 ☐ Digoxin | SS | 777 ☐ Occult Blood | STL | 605 ☐ Urine Culture | UR |
| | | 151 ☐ Dilantin | SS | 127 ☐ Phosphorus | SS | 605A ☐ Blood Culture | OT |
| | | | | 150 ☐ Phenobarbital | SS | 604 ☐ Throat Culture | SW |
| | | | | 151 ☐ Phenytoin | SS | 606 ☐ Wound Culture | SW |
| | | | | 134 ☐ Potassium | SS | 602 ☐ Stool Culture | ST |
| | | | | 913 ☐ Progesterone | SS | 601 ☐ Genital Culture | SW |
| | | | | 181 ☐ Prolactin | SS | 537 ☐ Miscellaneous Culture: | SW/OT |
| | | | | 194 ☐ PSA Free/Tot | SS | | |
| | | | | 196 ☐ PSA | SS | 2928 ☐ Trichomonas | UR |
| | | | | 787 ☐ PTH | SS | | |
| | | | | 247 ☐ Reticulocyte count | LV | | |

## CUSTOM PROFILES

**GYN/PAP:** ☐ GYN/PAP THIN-PREP
☐ VAG ☐ CERV ☐ ENDOCERV
☐ OTHER:_____
☐ **TISSUE PATHOLOGY**
SOURCE:
**OTHER MEDICAL DATA:**
☐ ABN BLEEDING ☐ HORMONE RX ☐ POST PARTUM
☐ PREGNANT ☐ IUD ☐ OTHER:_____
LMP _____/_____/_____
PREVIOUS SMEAR? ☐ YES ☐ NO
DATE:_____/_____/_____
PREVIOUS TEST RESULTS
FURTHER HISTORY

REQUIRES SPECIFIC DIAGNOSIS
*Please read and sign informed consent on reverse side.

BARCODE 1234567

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|---|---|
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| SS SEP | LV LAV | GY GRAY | BL BLUE | GN GREEN | RE RED | YE YELLOW | BX TISSUE | UR URINE | UA U24 | UC URICLT | SW SWAB | SL SLIDE | ST STOOL | PNK PINK | OT OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |

Version 20200313

# PANELS

*PLEASE WRITE TEST CODE IN "CUSTOM PROFILES" SECTION ON FRONT

| 1545 | 2590 | 3580 | 4577 | 6675 |
|---|---|---|---|---|
| **CARDIAC PANEL** | **CELIAC DISEASE PANEL** | **FERTILITY PANEL** | **ACUTE HEPATITIS PANEL** | **FOOD ALLERGY PROFILE** |
| TROPONIN I, CKMB (Incl. CPK), PRO-BNP hs CRP HOMOCYSTEINE | GLIADIN IGG/IGA, TTG IGG/IGA, IGA DEFICIENCY TEST INCLUDED | FSH, LH PROLACTIN, TESTOSTERONE, ESTRADIOL, PROGESTERONE | HEP A AB IGM, HEP B CORE, HEP B SUR AG, HEP SUR AB, HEP C AB | CLAM, CORN, EGG WHITE, CODFISH, COWS MILK, PEANUT, SHRIMP, SOYBEAN, WALNUT, WHEAT |

| 7500 | 8525 |
|---|---|
| **RESPIRATORY ALLERGY PROFILE** | **CHEM 29 PANEL** |
| Total IgE, D. pteronyssinus (House Mite), D. Farinae (House Mite), Cat Epithelium, Dog Epithelium, Timothy Grass, Cockroach, Cladosporium, Herbarum, Asperfillus Fumigatus, Alternaria Tenius, Box Elder/Maple, Oak, Elm, Ragweed, Common, Lamb's Quarters (Goosefoot) | ALBUMIN, ALKALINE PHOSPHATASE, TOTAL BILIRUBIN, BUN/CREATININE RATIO, CALCIUM, CHLORIDE, CHOLESTEROL, CHOL/HDL, C02, CREATININE, GLUCOSE, HDL CHOLESTEROL, LDL/HDL RATIO, PERCENT HDL, PHOSPHORUS, POTASSIUM, AST, ALT, SODIUM, TOTAL PROTEIN, TRIGLYCERIDES, BUN, URIC ACID, GGT, LDH, IRON, GLOBULIN |

## Informed Consent to Perform HIV Testing

I agree to testing for HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

**For pregnant women only:**
**In addition to the testing described above, I authorize my health care professional to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.**

Signature: _____ Date:_____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject:_____

Printed Name_____

**ADVANCE BENEFICIARY NOTICE (ABN)**
**To the Beneficiary:** Your physician may sometimes order laboratory testing that he or she believes to be necessary for your care, but which does not qualify for coverage under Medicare's standards. Medicare will only pay for services that it determines to be "reasonable and necessary" based upon the diagnosis information furnished to AMEDIX LABORATORY by your physician. If, *under Medicare's standards*, your diagnosis does not support the testing ordered, Medicare will deny coverage. In those cases where Medicare denies coverage, the billing will be forwarded to you, and you will be responsible for the cost of the laboratory tests.
Beneficiary Agreement: I have been notified by my physician/supplier that he or she believes that, in my case, Medicare may deny payment for the services identified above. If Medicare denies payment, I agree to be personally and fully responsible for payment.