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Practice Information:

Requesting Provider:

OB PANEL REQUISITION

Patient's Last Name:	First:	MI:	SSN#
Sex: M F	DOB:	Date / Time Collected:	MRN:
Relationship to Insured/Responsible Party: _____Self _____Spouse _____Dependent			
Address of Patient:			Patient Phone:
City, State, and Zip Code:		Name of Insured/Responsible Party if not patient	

Bill To:	Insurance Company Name (Please attached a copy of card front & back):	
□ Medicare □ Medi-cal / Medicaid	Insurance ID#:	Group#:
□ Patient □ Insurance (PPO) □ Other:________________	Medi-Cal # / Medicaid #:	Medicare #:

DIAGNOSIS CODES (ICD CODES)

PANELS

Test	Tube
□ Lipid Panel (fasting)	S
□ Lipid Panel w/reflex DLDL	S
□ Hepatic Panel	S
□ Obstetric Panel w/reflex	Y,L,S

HEMATOLOGY

Test	Tube
□ Hemoglobin	L
□ Hematocrit	L
□ CBC 3part Diff	L
□ PT with INR	B
□ PTT, Activated	B

OTHER TESTS

Test	Tube
□ Albumin	S
□ Alkaline Phosphatase	S
□ ALT	S
□ Antibody Screen	Y
□ ABO Group & RH Type	Y,L
□ AST	S
□ Bilirubin, Direct	S
□ Bilirubin, Total	S
□ CA 125	S
□ Cholesterol	S
□ Creatinine	S
□ Estradiol	S
□ Ferritin	S
□ FSH	S
□ GGT	S
□ Glucose Gestational Screen	GY
□ Glucose Gestational Screen	GY
□ Glucose Plasma	GY

OTHER TESTS

Test	Tube
□ hCG, Total, Quant	S
□ HDL-Cholesterol	S
□ HE-4 Ovarion Cancer Monitoring	SR
□ Hepatitis B Surface AG w/reflex Confirm	S
□ HIV-1/2 AG/AB*4th w/reflex	S
□ Homocysteine	S
□ CRP HS	S
□ Herpes I IgG	S
□ Herpes II IgG	S
□ Herpes I & II IgG	S
□ Iron	S
□ Iron, TIBC, %Sat	S
□ LDLCholesterol Direct	S
□ LH	S
□ Parogesterone	S
□ Prolactin	S
□ RPR Screen w/reflex Titer	S
□ RPR w/reflex Confirm	S
□ Rubella	S
□ Testosterone, Total	S
□ Total Protein	S
□ Triglycerides	S
□ TSH	S
□ TSH w/reflex T4 Free	S
□ T4 Free	S
□ UA Dipstick	U
□ UA Dipstick w/reflex Microscopic	U
□ UA Complete Dipstick&Microscopic	U
□ Urea Nitrogen (BUN)	S

OTHER TESTS

Test	Tube
□ Uric Acid	S
□ Vitamin D, 25 Hydroxy	S
□ Vitamin B 12	S

MICROBIOLOGY

Test	Tube
□ Culture, Aerobic Bacteria	SW
□ Culture, Aerobic Bacteria w/ Gram Stain	SW
□ Culture, Genital	SW
□ Culture, Streptococcus Group B	SW
□ Culture, Urine Routine	STC
□ Gram Stain	

- ***Addititional Charge for ID Susceptibility Studies***

HOLOGIC MOLECULAR APTIMA

Test	Tube
□ Chlamydia & Gonorrhoease	U
□ HPV	TP
□ Trichomonas	TP

GENOTYPE

□ DNA/RNA HIV
□ Cytomegalovirus
□ DNA / Hepatitis B
□ DNA / HIV Reverse
□ DNA / RNA Hepatitis C

PATHOLOGY

□ Tissue Pathology

Anatomic Site	Procedure	Impression

Physician Signature:__________________________ Date:________________

Patient Signature:__________________________ Date:________________

Collector Signature:__________________________ Date:________________