Requisitions – Southwestern Vermont Medical Center

Guidelines for Completing an Outpatient Laboratory Requisition

REQUIRED PATIENT DATA

1. Enter patient's FULL LEGAL name, date of birth, and sex.
2. Use the CLINICAL DIAGNOSIS box to enter all diagnosis codes or descriptions that apply for the test(s) being ordered (Refer to guidelines).
3. For customized physician/group practice requisitions, circle the name of the ordering physician.
4. If the requisition is not customized, enter the ordering physicians name, address and telephone number.

REQUIRED SPECIMEN DATA

1. If including your patient demographic/insurance sheet, check the PT Data Sheet Attached box and skip to the OTHER PHYSICIAN INFORMATION section of the requisition
2. If the PT Date Sheet is not included, enter the patient's telephone number, insurance name(s) and insurance policy and/or group numbers.
3. If the patient has no insurance please write SELF PAY in the Insurance Name #1 box.

OTHER PHYSICIAN INFORMATION

1. Enter the name of the patient's PCP/family physician.
2. Indicate if copies of the report are to be sent to ADDITIONAL physicians. If the physician is out of the service area, please indicate their mailing address for the report as well as the phone number in case we need to contact this physician.
3. Indicate if the test results are to be called or faxed; enter the phone number(s) and recipients.
   (It is a HIPPA requirement that all call and fax numbers be accompanied with the name of the recipient of the information.)
4. ALWAYS have the patient sign the requisition to allow SVMC to bill for the services provided.
5. Orders from New York State also need the ordering physician's signature.

SPECIMEN INFORMATION

1. For specimens collected in the office, indicate the date and time the specimen was drawn. If SVMC lab is to collect the specimen, leave the date and time fields blank.
2. Check the box(es) if the patient was or is to be Fasting or Non-Fasting, and if the testing is to be run STAT or is a PRE-OP patient.
3. Mark all the tests needed by placing an "X" in the box(es) next to the test name. Some microbiology specimens will also require a specimen source to be indicated or ask about pregnancy or allergy status.
4. Test orders not on the list of tests may be entered in the OTHER TEST/COMMENTS section at the bottom of the requisition.

NOTES

1. IF THE PATIENT HAS MEDICARE INSURANCE AND ANY TEST(S) WITH AN "*" HAVE BEEN MARKED, MEDICAL NECESSITY MUST BE DETERMINED FOR THOSE TESTS PRIOR TO SUBMISSION TO THE LAB AND BEFORE THE PATIENT LEAVES THE OFFICE. There may be additional tests requiring medical necessity

checking that are not included on the Lab requisition. Refer to master list of tests provided in the Medical Necessity manual.

2. If a test fails medical necessity checking based on the diagnosis given, the chart or physician must be consulted to determine if additional patient diagnoses can be provided that warrant the test(s) being done.
3. Any additional diagnoses provided for the testing must be entered onto the Lab requisition in the REASON FOR TEST section.
4. If the test(s) does not pass medical necessity and no further diagnosis can be provided, it is requested that the physician's office print out an ABN, advise the patient of their liability, give them the choices available, and have the patient sign and date it. **A copy of the ABN should be submitted with the requisition.** Every effort should be made to provide a valid diagnosis for the patient.
5. Not submitting the ABN to the Lab may result in delayed testing and an inconvenience to the office practice and patient by unnecessary phone call

OUTPATIENT LABORATORY REQUISITION (FRONT)

Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

OUTPT FAX (802) 447-6240
Lab Phone (802) 447-5340 Lab Fax (802) 447-5338

OUTPATIENT LABORATORY REQUISITION

REQUIRED PATIENT DATA

LEGAL NAME: (LAST) (FIRST) (MI)

DATE OF BIRTH: SEX: M F

REASON FOR TEST(S): [ICD-9 code, symptom, sign, Clinical History]

ORDERING PHYSICIAN:

☐ PT Data Sheet Attached

REQUIRED SPECIMEN DATA

PATIENT TELEPHONE NO.:

INSURANCE NAME #1: INSURANCE NAME #2:

INSURANCE POLICY No. #1: INSURANCE POLICY No. #2:

INSURANCE GROUP No. #1: INSURANCE GROUP No. #2:

OTHER PHYSICIAN INFORMATION

FAMILY/PRIMARY CARE PHYSICIAN:

OTHER COPIES TO: *address if out of service area*

☐ CALL #: RECIPIENT:

☐ FAX #: RECIPIENT:

NOTICE TO PHYSICIANS

YOU SHOULD ONLY ORDER THOSE TESTS YOU BELIEVE ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF YOUR PATIENT. MEDICARE MAY DENY PAYMENT FOR A TEST YOU BELIEVE IS APPROPRIATE, SUCH AS SCREENING TEST, BUT WHICH DOES NOT MEET THE MEDICARE DEFINITION OF MEDICAL NECESSITY.

PHYSICIAN SIGNATURE: DATE:

RELEASE OF AUTHORIZATION

I HEREBY AUTHORIZE SOUTHWESTERN VERMONT MEDICAL CENTER (SVMC) TO RELEASE INFORMATION PERTAINING TO THIS CARE TO MY HEALTH INSURANCE CARRIER. I ALSO AUTHORIZE DIRECT PAYMENT OF THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

PATIENT SIGNATURE: DATE:

SPECIMEN INFORMATION

☐ ADD-ON ORDER
☐ VERBAL ORDER F/U

DATE COLLECTED	TIME COLLECTED	STATUS
		☐ FASTING ☐ NON FASTING

☐ STAT ☐ PRE-OP

ABORH	ABO/RH TYPE	PTT	PTT *
TS	TYPE & SCREEN	RPR	RPR
ALB	ALBUMIN	SR	ESR SEDIMENTATION RATE
AP	ALKALINE PHOSPHATASE	NA	SODIUM
ALT	ALT	TRIG	TRIGLYCERIDES * F
AMY	AMYLASE	TSHR	TSH REFLEX CASCADE (TO FT4, T3T) *
AST	AST	TSH	TSH *
BILD	BILIRUBIN, DIRECT	T4	T-4 (THYROXINE) *
BILT	BILIRUBIN, TOTAL	T4FREE	T-4, FREE *
BUN	BUN (UREA NITROGEN)	URCA	URIC ACID
CAL	CALCIUM	UAR	UA w/reflex SED & CULTURE * Pregnant? Y / N Pen. Allergy? Y / N
CO2	CARBON DIOXIDE (CO2)	UA	URINALYSIS w/ reflex SED
CBCD	CBC w/PLTS + Electronic Diff. *	USEDX	SEDIMENT EXAM, URINE
CBCP	CBC w/PLTS *	B12	VITAMIN B12
CEAA	CEA (ABBOT) *	WBC	WHITE BLOOD CELLS *
CL	CHLORIDE		**PANELS**
CHOL	CHOLESTEROL, TOTAL * F	BMP	BASIC METABOLIC PANEL F
CRE	CREATININE	CMP	COMP METABOLIC PANEL F
DAT	COOMBS TEST, DIRECT	LYTES	ELECTROLYTE PANEL F
DAU	DRUG SCREEN, URINE	HFP	HEPATIC FUNCTION PANEL F
DIG	DIGOXIN *	LP	LIPID PANEL * F
FOLATE	FOLIC ACID	OBP OBS	OBSTETRIC PANEL
GGT	GGT *	RFP	RENAL FUNCTION PANEL F
GLU	GLUCOSE * F		**MICROBIOLOGY**
GLUPS	PREGNANCY DIABETIC SCR.	CHLAM-DNA	CHLAMYDIA DNA PROBE #
HCT	HEMATOCRIT *	GCDNA	GC DNA PROBE #
HGB	HEMOGLOBIN *	CDT	CLOSTRIDUM DIFFICILE TOXIN
HCG	HCG, SERUM (QUAL) *	GLAG	GIARDIA ANTIGEN
HCGQN	HCG, SERUM QUANT) *	GASS	GRP A STREP AG w/ reflex culture
HDL	HDL * F	OP	OVA & PARASITES
HEMA1C	HEMOGLOBIN A1C *		**CULTURES**
HBSAG	HEP B SURFACE AG	NC	SINUS OR NASAL
	HIV w/ REFLEX to WB if POSITIVE	SPTC	SPUTUM w/ GRAM STAIN
IRNP	IRON, TIBC, % SAT *	STS	MRSA SCREEN
IRN	IRON TOTAL *	SC	STOOL W/ ECOLI 0157 SCREEN
LD	LDH	SAS	THROAT, STREP A ONLY
LYME	LYME AB w/reflex WB if pos.	SBS	STREP B ONLY; GBS Pregnant? Y / N Pen. Allergy? Y / N
MDIFF	WBC MANUAL DIFFERENTIAL *	TC	THROAT, STREP & H. FLU
PHOS	PHOSPHORUS	UC	URINE * Pregnant? Y / N Pen. Allergy? Y / N
K	POTASSIUM	VAGC	VAGINAL OR CERVICAL
PROT	PROTEIN, TOTAL	WC	WOUND w/ GRAM STAIN #
PSAS	PSA SCREENING *		# SOURCE
PSAD	PSA DIAGNOSTIC *		
PT	PROTIME (WITH INR) *		

OTHER TESTS OR COMMENTS

F = Fasting recommended * = Medicare Medical necessity needed

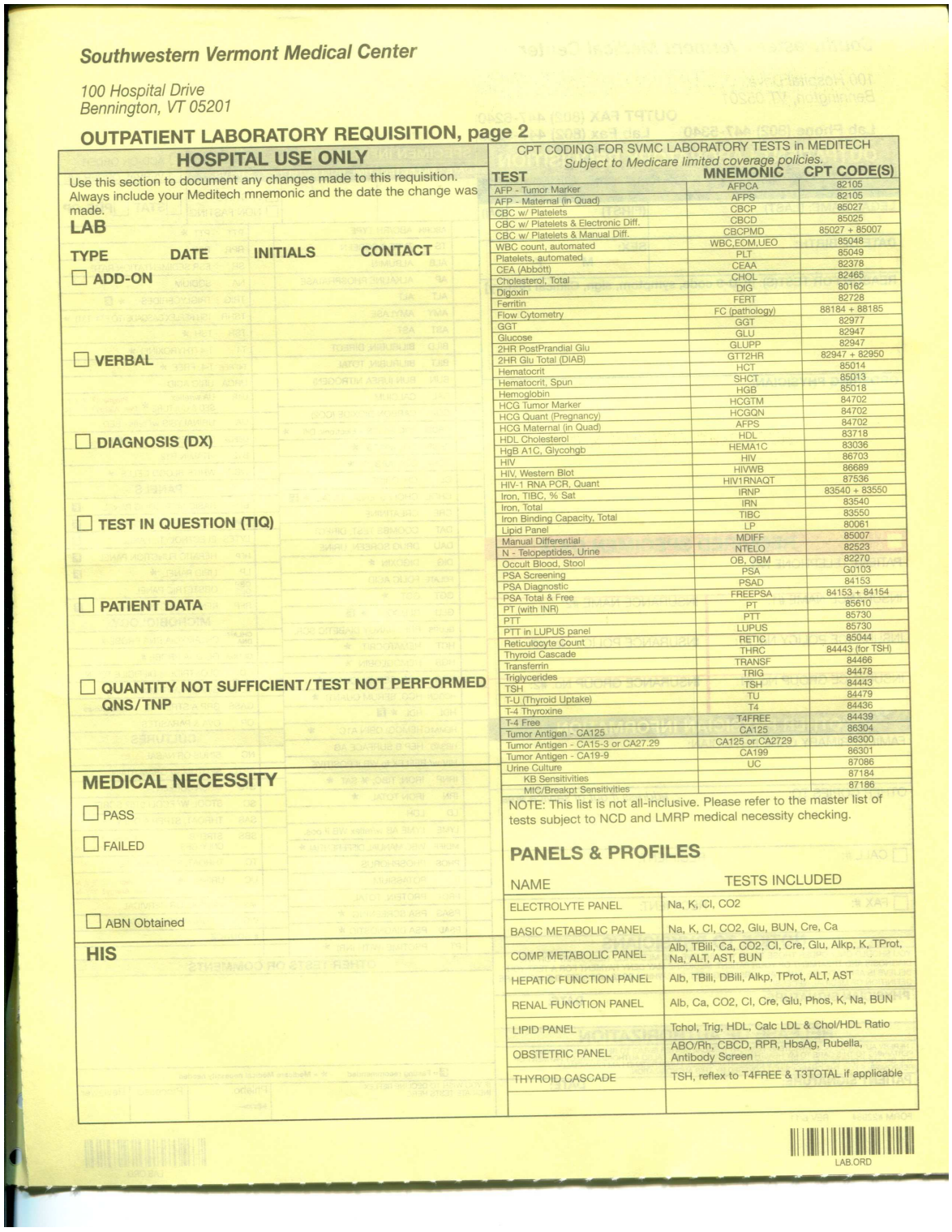
IF YOU WISH TO DECLINE REFLEX INDICATE TESTS HERE

Phlebo.	Processor	Reviewer

FORM #22984 REV 6/11

LAB.ORD

OUTPATIENT LABORATORY REQUISITION (BACK)



Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

OUTPATIENT LABORATORY REQUISITION, page 2

HOSPITAL USE ONLY

Use this section to document any changes made to this requisition. Always include your Meditech mnemonic and the date the change was made.

LAB

TYPE	DATE	INITIALS	CONTACT
☐ ADD-ON			
☐ VERBAL			
☐ DIAGNOSIS (DX)			
☐ TEST IN QUESTION (TIQ)			
☐ PATIENT DATA			
☐ QUANTITY NOT SUFFICIENT/TEST NOT PERFORMED QNS/TNP			

MEDICAL NECESSITY

☐ PASS

☐ FAILED

☐ ABN Obtained

HIS

CPT CODING FOR SVMC LABORATORY TESTS in MEDITECH
Subject to Medicare limited coverage policies.

TEST	MNEMONIC	CPT CODE(S)
AFP - Tumor Marker	AFPCA	82105
AFP - Maternal (in Quad)	AFPS	82105
CBC w/ Platelets	CBCP	85027
CBC w/ Platelets & Electronic Diff.	CBCD	85025
CBC w/ Platelets & Manual Diff.	CBCPMD	85027 + 85007
WBC count, automated	WBC,EOM,UEO	85048
Platelets, automated	PLT	85049
CEA (Abbott)	CEAA	82378
Cholesterol, Total	CHOL	82465
Digoxin	DIG	80162
Ferritin	FERT	82728
Flow Cytometry	FC (pathology)	88184 + 88185
GGT	GGT	82977
Glucose	GLU	82947
2HR PostPrandial Glu	GLUPP	82947
2HR Glu Total (DIAB)	GTT2HR	82947 + 82950
Hematocrit	HCT	85014
Hematocrit, Spun	SHCT	85013
Hemoglobin	HGB	85018
HCG Tumor Marker	HCGTM	84702
HCG Quant (Pregnancy)	HCGQN	84702
HCG Maternal (in Quad)	AFPS	84702
HDL Cholesterol	HDL	83718
HgB A1C, Glycohgb	HEMA1C	83036
HIV	HIV	86703
HIV, Western Blot	HIVWB	86689
HIV-1 RNA PCR, Quant	HIV1RNAQT	87536
Iron, TIBC, % Sat	IRNP	83540 + 83550
Iron, Total	IRN	83540
Iron Binding Capacity, Total	TIBC	83550
Lipid Panel	LP	80061
Manual Differential	MDIFF	85007
N - Telopeptides, Urine	NTELO	82523
Occult Blood, Stool	OB, OBM	82270
PSA Screening	PSA	G0103
PSA Diagnostic	PSAD	84153
PSA Total & Free	FREEPSA	84153 + 84154
PT (with INR)	PT	85610
PTT	PTT	85730
PTT in LUPUS panel	LUPUS	85730
Reticulocyte Count	RETIC	85044
Thyroid Cascade	THRC	84443 (for TSH)
Transferrin	TRANSF	84466
Triglycerides	TRIG	84478
TSH	TSH	84443
T-U (Thyroid Uptake)	TU	84479
T-4 Thyroxine	T4	84436
T-4 Free	T4FREE	84439
Tumor Antigen - CA125	CA125	86304
Tumor Antigen - CA15-3 or CA27.29	CA125 or CA2729	86300
Tumor Antigen - CA19-9	CA199	86301
Urine Culture	UC	87086
KB Sensitivities		87184
MIC/Breakpt Sensitivities		87186

NOTE: This list is not all-inclusive. Please refer to the master list of tests subject to NCD and LMRP medical necessity checking.

PANELS & PROFILES

NAME	TESTS INCLUDED
ELECTROLYTE PANEL	Na, K, Cl, CO2
BASIC METABOLIC PANEL	Na, K, Cl, CO2, Glu, BUN, Cre, Ca
COMP METABOLIC PANEL	Alb, TBili, Ca, CO2, Cl, Cre, Glu, Alkp, K, TProt, Na, ALT, AST, BUN
HEPATIC FUNCTION PANEL	Alb, TBili, DBili, Alkp, TProt, ALT, AST
RENAL FUNCTION PANEL	Alb, Ca, CO2, Cl, Cre, Glu, Phos, K, Na, BUN
LIPID PANEL	Tchol, Trig, HDL, Calc LDL & Chol/HDL Ratio
OBSTETRIC PANEL	ABO/Rh, CBCD, RPR, HbsAg, Rubella, Antibody Screen
THYROID CASCADE	TSH, reflex to T4FREE & T3TOTAL if applicable

LAB.ORD

OUTPATIENT CYTOLOGY & PATHOLOGY REQUISITION (FRONT)

Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

Lab Phone (802) 447-5340 **Lab Fax (802) 447-5338**

OUTPATIENT CYTOLOGY & PATHOLOGY REQUISITION

REQUIRED PATIENT DATA

LEGAL NAME: (LAST)	(FIRST)	(MI)

DATE OF BIRTH:	SEX: M F

CLINICAL DIAGNOSIS: (ICD-9 Codes, Symptoms, Signs)

ORDERING PHYSICIAN:

☐ PT Data Sheet Attached

REQUIRED SPECIMEN DATA

PATIENT TELEPHONE NO.:

INSURANCE NAME #1:	INSURANCE NAME #2:
INSURANCE POLICY No. #1:	INSURANCE POLICY No. #2:
INSURANCE GROUP No. #1:	INSURANCE GROUP No. #2:

OTHER PHYSICIAN INFORMATION

FAMILY/PRIMARY CARE PHYSICIAN:

OTHER COPIES TO: *address if out of service area*

☐ CALL #: RECIPIENT:

☐ FAX #: RECIPIENT:

NOTICE TO PHYSICIANS

YOU SHOULD ONLY ORDER THOSE TESTS YOU BELIEVE ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF YOUR PATIENT. MEDICARE MAY DENY PAYMENT FOR A TEST YOU BELIEVE IS APPROPRIATE, SUCH AS SCREENING TEST, BUT WHICH DOES NOT MEET THE MEDICARE DEFINITION OF MEDICAL NECESSITY.

PHYSICIAN SIGNATURE: **DATE:**

RELEASE OF AUTHORIZATION

I HEREBY AUTHORIZE SOUTHWESTERN VERMONT MEDICAL CENTER (SVMC) TO RELEASE INFORMATION PERTAINING TO THIS CARE TO MY HEALTH INSURANCE CARRIER. I ALSO AUTHORIZE DIRECT PAYMENT OF THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

PATIENT SIGNATURE: **DATE:**

SPECIMEN INFORMATION

DATE COLLECTED	DATE RECEIVED	☐ ADD-ON ORDER ☐ VERBAL ORDER F/U

CG -	CN -	SP -

SURGICAL PATHOLOGY SPECIMENS

Specimen Type:	Specimen Source:

CLINICAL HISTORY:

CYTOLOGY NON-GYNECOLOGICAL SPECIMENS

Specimen Type:	Specimen Source:

CLINICAL HISTORY:

CYTOLOGY GYNECOLOGICAL SPECIMENS

Specimen Source:

☐ VAGINAL ☐ CERVICAL ☐ OTHER:

Pregnant? ☐ Yes ☐ No **Postpartum?** ☐ Yes ☐ No **IUD?** ☐ Yes ☐ No

Last PAP Test: _____/_____/_____

First Day LMP: _____/_____/_____

PAP TEST

☐ LOW RISK / SCREENING - THIN PREP (CYGTP) G0123*

☐ HIGH RISK / DIAGNOSTIC - THIN PREP (CYGTPH) 88142*
Indicate reason (clinical history) below for high risk / diagnostic status

☐ HPV TEST (HPV) 87621# (regardless of Cytologic diagnosis)
#Source ☐ Thin Prep Vial

*All ASCUS or ASC-H Pap results will be reflexed for HPV testing.

CLINICAL HISTORY:

If you wish to decline reflex, indicate test(s) here:	Processor	

FORM #59392 REV 4/07

LAB COPY

OUTPATIENT CYTOLOGY & PATHOLOGY REQUISITION (BACK)

Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

OUTPATIENT CYTOLOGY & PATHOLOGY REQUISITION, page 2

HOSPITAL USE ONLY

Use this section to document any changes made to this requisition. Always include your Meditech mnemonic and the date the change was made.

LAB

TYPE	DATE	INITIALS	CONTACT
☐ ADD-ON			
☐ VERBAL			
☐ DIAGNOSIS (DX)			
☐ TEST IN QUESTION (TIQ)			
☐ PATIENT DATA			
☐ QUANTITY NOT SUFFICIENT/TEST NOT PERFORMED (QNS/TNP)			

MEDICAL NECESSITY

☐ PASS

☐ FAILED

☐ ABN Obtained

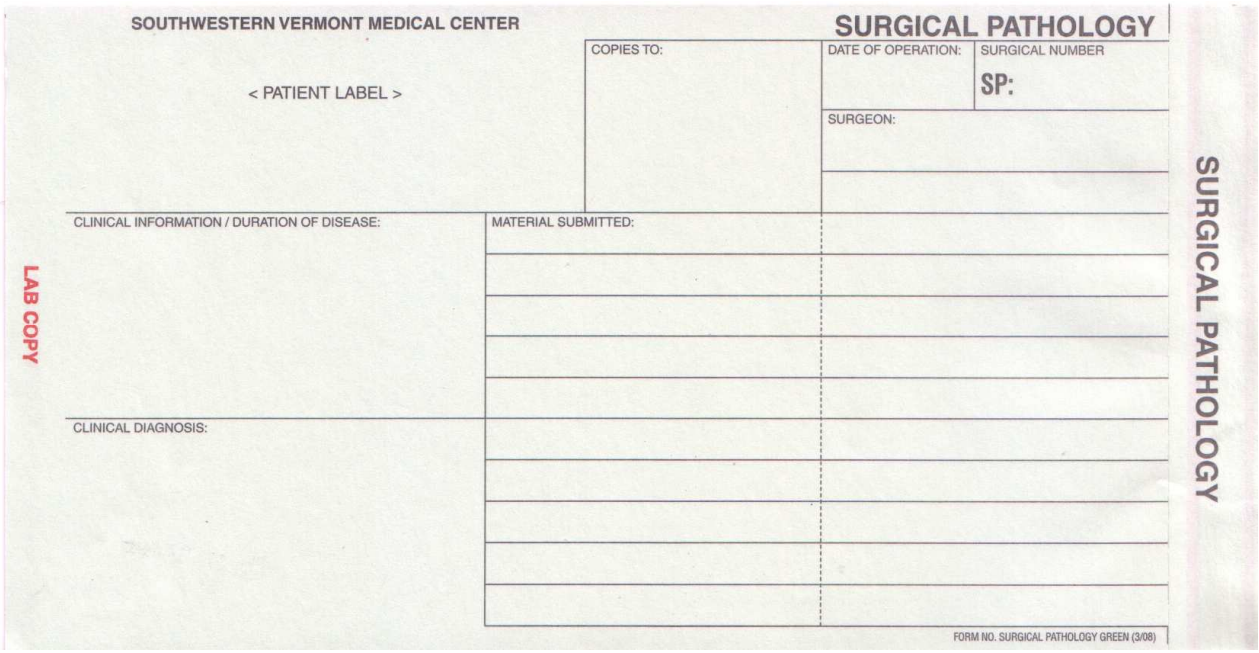
HIS

BILL TO:

FOR LAB BILLING USE ONLY

Billing #	Quant.	Description
40142266		Block - Client / Veterinary
40142223		Special Stain - Client / Veterinary
40140100		Brain Autopsy
40140110		Clerical Charge (per hr)
40122237		Dry Ice (per block)
40122235		Shipping Fee (variable)

SURGICAL PATHOLOGY INPATIENT FORM



SOUTHWESTERN VERMONT MEDICAL CENTER

SURGICAL PATHOLOGY

< PATIENT LABEL >

COPIES TO:

DATE OF OPERATION:

SURGICAL NUMBER

SP:

SURGEON:

CLINICAL INFORMATION / DURATION OF DISEASE:

MATERIAL SUBMITTED:

CLINICAL DIAGNOSIS:

FORM NO. SURGICAL PATHOLOGY GREEN (3/08)

LAB COPY

SURGICAL PATHOLOGY

OUTPATIENT LABORATORY STANDING ORDER REQUISITION

Southwestern Vermont Health Care

100 Hospital Drive
Bennington, VT 05201

OUTPATIENT LABORATORY STANDING ORDER REQUISITION

PHYSICIAN INSTRUCTIONS: **ALWAYS** include first and last name for each physician. For out-of-area physicians, a full name, address and phone/fax numbers are needed. **This standing order will expire in six months**.

PATIENT INSTRUCTIONS: Patient is responsible for bringing the standing order requisition to **EACH** visit. This standing order will expire in six months. Contact your doctor to update this order **before** the expiration date.

REQUIRED PATIENT DATA

LEGAL NAME: (LAST) | (FIRST)

D.O.B.: | SEX: M F

REASON FOR TEST(S): [ICD-9 code, symptom, sign, clinical history]

Ordering Physician:

(FULL Address and Phone # if Out-Of-Area Physician)

REQUIRED SPECIMEN DATA

Patient Telephone No.:

Insurance Name #1: | Insurance Name #2:

Insurance Policy No. #1: | Insurance Policy No. #2:

Insurance Group No. #1: | Insurance Group No. #2:

OTHER PHYSICIAN INFORMATION

Family/Primary Care Physician:

Other Copies to: *address is out of service area*

☐ Call #: Recipient:

☐ Fax #: Recipient:

STANDING ORDER TEST INFORMATION

Test	Frequency

☐ FASTING ☐ NON FASTING

Test Instructions:

NOTICE TO PHYSICIANS

FOR MEDICARE PATIENTS YOU SHOULD ONLY ORDER THOSE TESTS YOU BELIEVE ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF YOUR PATIENT. MEDICARE MAY DENY PAYMENT FOR A TEST YOU BELIEVE IS APPROPRIATE, SUCH AS A SCREENING TEST, BUT WHICH DOES NOT MEET THE MEDICARE DEFINITION OF MEDICAL NECESSITY.

▶

Ordering Physician Signature **Date**

FOR LAB USE ONLY

Expiration Date:

Date Collected: | Time Collected:

Processor: | Reviewer:

RELEASE OF AUTHORIZATION

I HERBY AUTHORIZE SOUTHWESTERN VERMONT MEDICAL CENTER (SVMC) TO RELEASE INFORMATION PERTAINING TO THIS CARE TO MY HEATLH INSURANCE CARRIER. I ALSO AUTHORIZE DIRECT PAYMENT OF THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

▶

Patient Signature **Date**

CONTACT INFORMATION
Phone #: 802-447-5340
Lab Fax #: 802-447-5338 Outpt Fax #: 802-447-6240

BLOOD BANK THERAPUTIC PHLEBOTMY REQUISITION

Southwestern Vermont Health Care

100 Hospital Drive
Bennington, VT 05

BLOOD BANK THERAPEUTIC PHLEBOTOMY REQUISITION

PHYSICIAN INSTRUCTIONS: **ALWAYS** include first and last name for each physician. For out-of area physicians, a full name, address and phone/fax numbers are needed. **This standing order will expire in six months**. Fax or send to Hospital Main Lab - ATTN: Bill or Cherie.

PATIENT DATA

Patient Name: _____
Last, First (please print)

D.O.B.: _____ SS No.: _____

Address: _____

City/State/Zip: _____

Telephone No.: _____

REFERRING ACCOUNT

Ordering Physician: _____
Last, First (please print)

PC Physician: _____
Last, First (please print)

Copy to Physician: _____
Last, First (please print)

FULL Address and Phone # if Out-Of-Area Physician:

_____

ORDER INFORMATION

Patient's Diagnosis: _____

_____

_____

_____

HCT or HGB at or above which patient is to be drawn:

HCT: _____ HGB: _____

FREQUENCY that patient should come to the Blood Bank:

_____

Additional Instructions (if any): _____

_____

_____

_____

NOTICE TO PHYSICIANS

FOR MEDICARE PATIENTS YOU SHOULD ONLY ORDER THOSE TESTS YOU BELIEVE ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF YOUR PATIENT. MEDICARE MAY DENY PAYMENT FOR A TEST YOU BELIEVE IS APPROPRIATE, SUCH AS A SCREENING TEST, BUT WHICH DOES NOT MEET THE MEDICARE DEFINITION OF MEDICAL NECESSITY.

▶ _____

Ordering Physician Signature **Date**

FOR LAB USE ONLY

Start Date: _____ Exp. Date: _____

Date of Collection: _____

Time of Collection: _____

Processor: _____ Reviewer: _____

▶ _____

Patient Signature **Date**

CONTACT INFORMATION
Phone #: 802-447-5340
Fax #: 802-447-5338