Specimen Information

___/___/___ Date Collected ______ Time Collected

Phlebotomist Initials ____________

Fasting: [ ] YES [ ] NO

PMH LABORATORY Inc.

"Excellence in Laboratory Medicine"

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(562) 592-2890 • Fax (909) 803-9790

SPECIMEN ID #

DATE RECEIVED

PANEL TEST REQUISITION

Patient Information

Patient Last Name

Date of Birth ___/___/___

Patient First Name, Middle Initial

Gender [ ] Male [ ] Female

[ ] **Uninsured Patient**

Patient Address

City

State

Zipcode

Practice Information

Requesting Provider ____________

REQUIRED

Bill Type: [ ] Insurance [ ] Medicare [ ] Medi-Cal [ ] Bill Patient
[ ] Bill Doctor [ ] Cash

Diagnostic Code(s)

ORDER TESTS

PROFILES		INDIVIDUAL TESTS		INDIVIDUAL TESTS		INDIVIDUAL TESTS	
[ ] Acute Hepatitis Profile *	GEL	[ ] C3	GEL	[ ] HIV-1/O2, 4thGeneration	GEL	[ ] SHBG	GEL
[ ] Basic Metabolic	GEL	[ ] C4	GEL	[ ] HCG, Quant. *	GEL	[ ] Testosterone Total	GEL
[ ] Comp Metabolic	GEL	[ ] CA 125 *	GEL	[ ] HCG, Qual. Serum	GEL	[ ] Testosterone Free	GEL
[ ] Electrolyte Profile	GEL	[ ] CA 15-3	GEL	[ ] HCG, Qual. Urine	GEL	[ ] Testosterone Free	GEL
[ ] (Liver) Hepatic Profile *	GEL	[ ] CA 19-9 (Xr) *	GEL	[ ] HE-4	GEL	[ ] Theophylline	SS
[ ] Lipid Profile *	GEL	[ ] Carbamazepine (Tegretol)	GEL	[ ] HDL Cholesterol	GEL	[ ] T3 Free *	GEL
[ ] Lipid w/LDL/HDL Ratio *	GEL	[ ] Calcium	GEL	[ ] Hemoglobin A1c *	LAV	[ ] T3 Total *	GEL
[ ] Lipid w/TC-HDL Ratio *	GEL	[ ] Calcium Arsenazo	GEL	[ ] HIV-1/O2, 4th Generation	GEL	[ ] T3 Uptake *	GEL
[ ] Obstetric Profile	SS & LAV	[ ] Calcium oCPC	GEL	[ ] Homocysteine	GEL	[ ] T4, Free *	SS
[ ] Renal Function Profile	GEL	[ ] CEA	GEL	[ ] HPV (Hologic)	THIN PREP	[ ] T4, Total *	GEL
HEMATOLOGY		[ ] Chlamyida (Hologic)	UA	[ ] IgA	GEL	[ ] T-Uptake	GEL
[ ] CBC wDiff *	LAV	[ ] Cholesterl, Total	GEL	[ ] IgG	GEL	[ ] TPO-Anti	GEL
[ ] CBC w/o Diff w Plt *	LAV	[ ] Cholinesterase	GEL	[ ] IgM	GEL	[ ] Tg-Anti	GEL
[ ] Hematocrit	LAV	[ ] CK	GEL	[ ] Iron	GEL	[ ] TSH 3rd Generation *	GEL
[ ] Hemoglobin	LAV	[ ] CK-MB	GEL	[ ] Insulin	GEL	[ ] Transferrin	GEL
[ ] Platelet Count	LAV	[ ] Ceruloplasmin	GEL	[ ] Lactate	GEL	[ ] Triglycerides	GEL
[ ] RBC Count	LAV	[ ] Cortisol	GEL	[ ] Lactate Dehydrogenase S	GEL	[ ] Troponin-1	GEL
[ ] WBC Count	LAV	[ ] C-Reactive Protein	GEL	[ ] LDH	GEL	[ ] Uric Acid	GEL
INDIVIDUAL TESTS		[ ] C-Reactive Protein HS	GEL	[ ] LDL Cholesterol	GEL	[ ] UA	Sterile Cont.
[ ] ABO and RH	LAV/SS	[ ]C-Reactive Protein (CRP)	GEL	[ ] LH	GEL	[ ] UA ,Reflex to C/S	Sterile Cont.
[ ] AFP	SS	[ ] Creatinine	GEL	[ ] Lithium	GEL	[ ] Urinary/CSF Protein	GEL
[ ] Albumin	GEL	[ ] Digoxin (Lanoxin)	GEL	[ ] Magnesium	GEL	[ ] UIBC	GEL
[ ] Alkaline Phosphatase	GEL	[ ] D-Dimer	GEL	[ ] Myoglobin	GEL	[ ] Vitamin D	GEL
[ ] ALT (SGPT)	GEL	[ ] DHEA-S	GEL	[ ] Microalbumin	GEL	**Therapeutic Drug Monitoring**	
[ ] Alpha-1-Acidglycoprotein	SS	[ ] Estradiol	GEL	[ ] Phenobarbital (Luminal)	SS	CALL LAB	
[ ] Alpha-1-Antitrypsin	SS	[ ] Ferritin	GEL	[ ] Phenytoin (Dilantin)	SS	**Drugs of Abuse**	
[ ] Amonia	SS	[ ] Folate	GEL	[ ] Phosphorus	GEL	CALL LAB	
[ ]Amylase	GEL	[ ] FSH	GEL	[ ] Potassium	GEL	***Clinical Information / Comments:***	
[ ] Antinuclear Antibodies	GEL	[ ] GGT	GEL	[ ] Progesterone	GEL		
[ ] Anti-Streptolysin O	SS	[ ] Glucose Fasting *	GRY	[ ] Prolactin	GEL		
[ ] Apolipoprotein A1	SS	[ ] Glucose Tolerance Test	GRY	[ ] PSA, Free	GEL		
[ ] Apolipoprotein B	SS	[ ] Gonorrhea (Hologic)	UA	[ ] PSA, Total *	GEL		
[ ] AST (SGOT)	GEL	[ ] Haptoglobin	GEL	[ ] Prothrombin Time (PT) INR	BLU		
[ ] B-12 Active	SS	[ ] HAV-Anti IgG	GEL	[ ] PT and PTT Activated	BLU		
[ ] B-12	SS	[ ] HAV-Anti IgM	GEL	[ ] PTT Activated	BLU		
[ ] B12 and Folate	GEL	[ ] HBc-Anti	GEL	[ ] Rheumatoid Factor (RF) SS	GEL		
[ ] Beta-2 Microglobulin	SS	[ ] HBc IgM-Anti	GEL	[ ] RPR / Syphilis Screen **	GEL		
[ ] BNP	GEL	[ ] HBs-Anti	GEL	[ ] RPR Titer**	GEL		
[ ] Bilirubin, Total	GEL	[ ] HCV-Anti	GEL	[ ] Rubella IgG	GEL		
[ ] BUN	GEL	[ ] HBsAg (Qual Conf)	GEL	[ ] Sed Rate, Westergren	LAV		
[ ] Calcium	GEL	[ ] HBsAg (Qualitative)	GEL	[ ] Sodium	GEL		

I, the undersigned, understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing the authorization, I allow the release of any medical information necessary to process this claim. By signing, I certify that I have provided an unadulterated sample to be analyzed. I acknowledge that the laboratory has permission to release my results directly to the treating physician or facility. PMH Laboratories Inc., also has my permission to outsource the processing of this sample at their discretion. I hereby authorize my insurance benefits to be paid directly to the laboratory for services rendered and I agree to endorse any payments received from my insurer and forward them to the Laboratory for services rendered.

Patient Signature: ____________ Date: ____________

I authorize the above ordered laboratory test(s). If no profile is selected. PMH Laboratories Inc., will refer to your custom profile for testing and any additional test you have ordered on this form.

Physician Signature: ____________ Date: ____________

Collector Signature: ____________ Date: ____________

PMH LAB Copy -White / Physician Copy - Yellow