Salem Health®
Hospitals & Clinics

Order Date: _____

Patient Name: _____

Patient Date of Birth: _____

Collection Info

Date: _____ Time: _____

Is the patient fasting? Yes / No Hours Fasting: _____

Who are we billing? (Circle One)
Patient (Insurance) / Facility

Diagnosis Code (ICD-10):
(Required when billing patient's insurance)
_____

Ordering Provider: _____
(Last Name, First Name)

Ordering Provider Address:

_____

Phone No: _____

Fax No: _____

Send Additional Reports To:

1) _____

2) _____

Note: Please attach patient's demographics

___ Basic Metabolic Panel (**MINI**)	SS
___ CBC with automated Diff (**CBC**)	LH
___ Comp Metabolic Panel (**CMET**)	SS
___ CRP (**CRP**)	SS
___ Folate/B12 (**FOB12**)	SS
___ Hemoglobin/Hematocrit (**HBHCT**)	LH
___ Hemoglobin A1C (**GLYCO**)	LH
___ Iron/Ferritin/Transferrin (**ITF**)	SS
___ Lipid Panel (**LIPSC**)	SS
___ Magnesium (**MG**)	SS
___ Phosphorus (**PHOS**)	SS
___ PSA (**PSAD**)	SS
___ Protime/INR (**PT**)	BB
___ PTT (**PTT**)	BB
___ Renal Function Panel (**RFP**)	SS

___ Sed Rate, Automated (**SEDR**)	LH
___ T4, Free (**FT4**)	SS
___ TSH (**TSH**)	SS
___ Vancomycin (**VANR/VANT**)	SS
Circle one: Trough / Random	
___ Vitamin D, 25 Hydroxy (**VITAD**)	SS

___ UA with Culture if Indicated Urine

Circle one: VOID / CATH

___ Urine Culture Only (**URC**) Urine

___ OTHER: _____

_____

_____

Highlighted tests may require Advance Beneficiary Notice

Specimen Codes
SS = Gold Top
LH = Purple Top
BB = Lt Blue Top