UFHealth
JACKSONVILLE

Bill: ☐ Client ☐ Patient ☐ Insurance	**Patient Name:**
Guarantor (if other than patient) / Group #	Patient Street Address:
Guarantor Address: City, State, Zip	City, State/Zip:
Workman's comp **Y** **N** / Date of Injury:	DOB : / MRN/Docket #
Employer's Name:	Patient Phone: / Gender **F** **M**
PRIMARY Insurance:	Client Information/ ICD-10 Codes:
Street Address:	
City/State/Zip:	
Policy #/ID: / Group #	
SECONDARY Insurance: Attach documentation	
Policy #/ID: / Group #	**Ordering Physician**:
Collection date: Collection Time:	☐**Routine** ☐**Stat call to #**_____

√	CHEMISTRY			Test Code
	BMP Basic Metabolic Panel		BMP Basic Metabolic panel	15
	CO2 (G/GO)			55
	Sodium (G/GO)			122
	Potassium (G/GO)			114
	Chloride (G/GO)			59
	Glucose (G/GO)			5106
	BUN (G/GO)			140
	Creatinine (G/GO)			5112
	Calcium (G/GO)	CMP Comprehensive Metabolic panel		53
	Total Protein (G/GO)		Hepatic	118
	ALP - Alk Phos (G/GO)			112
	Total Bilirubin (G/GO)			50
	Albumin (G/GO)			45
	AST/SGOT (G/GO)			131
	ALT/SGPT (G/GO)			132
	Direct Bilirubin (G/GO)			168
	CMP Comprehensive Metab. Panel (G/GO)			17
	Amylase (G/GO)			48
	Ammonia (L) on ice SHIP STAT			47
	Pro-BNP Brain Natriuretic Peptide			
	B-12 (G/GO)			106
	Folate (G/Go)			69
	Ferritin (G/GO)			68
	Hemoglobin A1C (L)			90
	Hepatic Function (Liver) Profile (G/GO)			20
	Cholesterol only (G/GO)			60
	Lipid Profile - Chol HDL LDL TRIG (G/GO)			18
	FSH (G/GO)			86
	LH Leutinizing hormone (G/GO)			87
	Lactic Acid / Lactate (G) on ice			95
	Lipase (G/GO)			99
	MG Magnesium (G/GO)			103
	Phosphorus (G/GO)			113
	Pregnancy HCG screen serum (R/GO)			5115
	Pregnancy Beta HCG Quant (R/GO)			5116

√	CHEMISTRY	Test Code
	PSA (G/GO)	116
	T3 Total (G/GO)	136
	T3 (Uptake) (G/GO)	135
	T4 (Thyroxine) (G/GO)	126
	Free T4 (G/GO)	127
	TSH (G/GO)	129
	Uric Acid (G/GO)	141
	Carbamazepine (G/GO)	21
	Keppra-Levetiracetam (R)	
	Lithium (G/GO)	29
	Phenobarbital (G/GO)	30
	Phenytoin Total (G/GO)	31
	Theophylline (G/GO)	35
	Urinalysis with Microscopic (Kit)	4653
	Urinalysis no Microscopic (Kit)	5019
	UA reflex Urine Cult (Kit)	
	HEMATOLOGY	
	PT (B)	**320**
	PTT (B)	**325**
	CBC w Diff (L)	**294**
	CBC w/o Diff (L)	293
	Hemoglobin & HCT (L)	753
	Hgb only (L)	291
	Sed Rate (L)	547

√	MICROBIOLOGY/ SEROLOGY	Test Code
	AFB Culture - Cup	2058
	ANA Antinuclear Ab- Red	147
	Chlamydia/GC Det. (Aptima or Roche kit)	5301
	Cryptococcal Ag (Red)	779
	C. Difficile Toxin STOOL	5052
	Culture – Throat E. Swab	
	Culture – Specify site:	
	Culture - Urine (Kit)	239
	Crypto/Giardia - STOOL	258
	Enteric Pathogens stool	5710
	FLU/RSV (NP swab UTM)	5206
	Hep B S AB (Red)	472
	Hepatitis Panel - Acute Hep A, B & C (Red)	551
	Hep B S Ag (Red)	2104-7101
	Hep C AB (Red)	868
	Herpes-HSV PCR (UTM)	5165
	HIV ½ screen (Red)	5156
	HIV viral load (Purple)	919
	Measles/Rubeola (Red)	657
	Mumps (R)	160
	Mononucleosis (R)	482
	Rheumatoid Factor (R)	1195
	Rubella Screen – Red	496
	Syphilis/RPR Red	51010
	BLOOD BANK	
	ABO/Rh (R/L)	895
	Antibody Screen † (R/L)	278
	Prenatal Panel † (R/L)	4034

Prenatal Panel Includes: ABO/Rh Antibody Screen, CBC, Hep B Ag, RPR, Rubella

Additional tests:

Downtime Pathology Specimens:
Surg/Path _____ GYN cyto -PAP_____
FNA _____Last Menst. Period _____
Non Gyn Cyto _____
Bone Marrow _____ Left / Right /Bilateral
Flow Cytometry: _____

Comments:

Shahla Masood, MD, Director is available for consultation of laboratory services (904) 244-4387 Laboratory Customer Service: 1-904-244-6040
UF Health Jacksonville Medical Center, Inc., 655 West Eighth Street, Jacksonville, FL 32209 Fax: 904-244-8134

Specimen containers: G = Green GO = Gold L = Lavender/Purple P = Pink R = Red UTM = Universal Transport Media

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Anatomic Pathology Requisition	
Patient information Must be filled out completely	**Provider information Must be filled out completely**
Last Name:	Ordering **Physician:**
First and middle name: **Sex: Male Female**	**Phone**: **Fax:**
Date of birth (MM/DD/YYYY):	Ordering physician NPI #:
Medical Record/Patient ID#:	Duplicate report sent to:
Specimen collected from service location:	Duplicate report fax:
◻Hospital inpatient	**Authorized Signature:**
◻Ambulatory surgical center	**Date:**
◻Hospital outpatient ◻Office/Non-hospital	
Billing Information: Must be filled out completely and copies of insurance attached to requisition. Missing data will cause delays in testing	
Along with this requisition, please include copies of insurance cards and identification	
- ICD-10 code:	
-The patient's demographics (face) sheet:	
-Both sides of the patient's insurance card(s); and	
-Any secondary insurance info. (if applicable)	
**An Advance Beneficiary Notice of Noncoverage form must be completed and attached for all Medicare patients. Please attach patient's pathology report, clinical history, and other applicable report(s).*	
Clinical history narrative/Clinical question*:	

Cytology Specimen Information:	**Specimen information: Anatomic pathology(LAB5114)**
Collection Date: Time: AM/PM	**Tissue biopsy (designate sites):**
Body Fluid:	**A.**
FNA (specify site) (LAB4644)	**B.**
Cyto Non-Gyn (**LAB5113)**	**C.**
FNA (specify site) (**LAB4644)**	**D.**
Flow cytometry:Flow cytometry for Lymphoma(**LAB5120)**Place in RPMI medium	**E.**
	F.
Microbiology orders:	**Breast Specific Requirements:**
◻**Wound Culture** (Aerobic only, includes gram stain) (**LAB2007)**	**Cold ischemia time < 1 hour:** ◻ Yes ◻ No
◻**Tissue Culture** (Aerobic only, includes gram stain) (**LAB898**)	**Fixative (neutral-buffered formalin):** ◻Yes ◻ No
◻**AFB Culture** (includes stain**) (LAB2058)**	**Fixation time 6 -72 Hour:** ◻ Yes ◻ No
◻**Fungus Culture** (includes stain) (**LAB2008)**	**Other Testing: (specify):**
◻**Body Fluid Culture** (for sterile body fluids only, includes gram stain) (**LAB269)**	
◻**Anaerobic Culture** (**LAB233)**	

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Bill: ☐Office ☐Patient ☐Insurance ☐Medicare ☐Medicaid	**CYTOLOGY REQUISITION**
Responsible party (if other than patient) Social Security No.	Patient Name:
Responsible party address, city/state/zip	Patient Street Address
Workman s comp? **Y** **N** Date of Injury or illness	City/State/Zip
If yes, Employer's name	Patient Social Security Number
Insurance: ATTACH FACE SHEET copy of card	Patient D.O.B F M sex of patient
	Patient Telephone Number:
City/State/Zip City/State/Zip	**Account Code**:
Policy No./ID Group #	Ordering Physician:
I assign payment for unpaid charges for tests performed. I understand that I am financially responsible for charges not covered by this authorization. A copy of this authorization may be used in lieu of the original. I request that payment from my insurance benefits be made on my behalf for any services furnished. I authorize medical or other information about me be released to the Centers for Medicare andMedicaid Services and its agents or my insurance carrier(s) to determine benefits for related services. I also understand and agree that it is my responsibility to be sure I am using the laboratory that is coveredby my insurance company.	Date collected: Time Collected:
	Notice to Physicians: Medicare will only reimburse laboratory tests for which medical necessity is documented. A diagnosis must be provided for each test ordered. If the diagnosis does not meet medical necessity, an ABN must be presented for the patient's signature at the time the test is ordered and before the test is performed. Medicare covers some screening tests with frequency limitations. Please consult the laboratory for the most current information regarding routine screenings. *Requires medical necessity documentation or ABN form. Reflex testing performed when indicated.
Signature **Date**	Routine ☐ Stat ☐ Call Result ☐

GYN CYTOLOGY

✓	GYN	✓	GYN	✓	GYN	✓	GYN
	Pap Liquid Based Screening*		**STATUS**		**ABNORMAL HX**		**CONTRACEPTIVE HX**
	Pap Liquid Based Diagnostic*		LMP (Date / /)		Previous Abnormal Cytology		Birth Control pill
	Pap Smear, Screening*		Pregnant Weeks:		Dt.:		Depo
	Pap Smear, Diagnostic*		Postpartum Weeks:		Dx :		ERT
	HPV TESTING		Hysterectomy		Previous Abnormal Biopsy		HRT
	Reflex if ASCUS		Hysterectomy: (Cervix Intact)		Dt.:		OCP
	HPV Testing regardless of DX		Menopausal		Dx:		IUD
	SOURCE		Postmenopausal		Abnormal Bleeding		Other:
	Cervical ☐ Vaginal		Irregular Menses		Abnormal Clinical Exam		
	Endocervical ☐ Cuff		Other:				
	Other						

FNA/NON-GYN CYTOLOGY

	FNA		NON - GYN		NON - GYN
	Fine Needle Aspiration		**BODY CAVITY FLUIDS**		**RESPIRATORY SPECIMENS**
	Exact Site		Pleural / Thoracentesis		Bronchial Washing
	Total # Slides		Ascites/Peritoneal/Paracentesis		Site:
	# Air Dried		Pericardial		
	# Fixed		Synovial / Joint Fluid		Bronchial Brushing
	Other		Pelvic Washing		Site:
	CANCER HISTORY		Gastric Washing		
			CSF / Cerebral Spinal Fluid		Tracheal Washing
			URINE SPECIMENS		Sputum
			Urine, Voided		**OTHER**
	TREATMENT HISTORY		Urine, Clean Catch		Nipple Discharge Rt Lt
	Chemotherapy		Urine, Catheterized		Tzanck Smear for Herpes
	Radiation		Bladder Washing		Conjunctival Smear
	Other		Urine, Illeal Conduit		Other
			Other		

PATHOLOGY

	SURGICAL PATHOLOGY	CLINICAL HX (*required).*
	Routine Surgical Specimen (specify site below) *must be submitted in formalin*	
	Immunofluorescence *MUST be submitted in immuno transport fluid*	
	Electron Microscopy *submit in EM fixative*	

SITE

SPECIMEN SITE (Required):
ICD-10 diagnosis codes: