FOR LAB USE ONLY:

ACCT.# _____

Scheduling:
Phone: (850) 416-2940
Hours: Mon - Fri, 7:00a - 5:30p
Lab Order **Fax Server:** (850) 416-7337

Ascension Sacred Heart Pensacola

Test Requisition

ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER

HOME HEALTH CARE AGENCY OR FACILITY:
FACILITY NAME: _____
FACILITY ADDRESS: _____
_____
DIRECT PHONE #: (____)____-_____

SPECIMEN
Collected By (First & Last Name): _____
Date Collected: _____ Time Collected: _____ AM / PM

ORDER DATE: ____/____/____

PATIENT'S FULL NAME: _____
Last First MI

DOB: ____/____/____ SSN: ____ - ____ - ____
PHONE #: (____) ____ - ____ SEX: M F
ADDRESS: _____
Insurance Carrier: _____
Policy #: _____ **Group #:** _____
Guarantor: ☐ Self ☐ Other: _____
Last First MI
DOB: ____/____/____ **Relationship:** _____ Phone #: (____)____-_____
Insurance Authorization #: _____ Exp. Date: ____/____/____

PROVIDER'S FULL NAME: _____
Last First MI
PROVIDER'S SIGNATURE: _____
Copy to Provider: _____
Last First MI
Provider's Phone #: (____)____-_____

☐ **Fax Report To:**	☐ **Critical Report To:**
Fax #:	Phone #:

☐ ***Ascension Sacred Heart Pensacola Diagnostic Center***
5147 N Ninth Ave # 1100
Phone: (850) 416-7796

☐ ***Studer Family Children's Hospital Lab Express***
1 Bubba Watson Dr
Phone: (850) 416-2826

☐ ***Lab Express at Airport Medical Park***
1549 Airport Blvd
Phone: (850) 416-7796

☐ ***Lab Express at Perdido Medical Park***
13137 Sorrento Rd
Phone: (850) 416-7906

☐ ***Lab Express at Tiger Point Medical Park***
4033 Gulf Breeze Pkwy
Phone: (850) 416-1281

☐ ***Lab Express at Pace Medical Park***
3754 US 90
Phone: (850) 416-5940

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. In the event that Ascension Sacred Heart Laboratory cannot perform a test ordered, a Reference Lab will be utilized. The Reference Lab will bill directly for tests performed.

TEST NAME ☐ Routine ☐ Stat ☐ Fasting	CPT CODE	DIAGNOSIS CODE
☐ Alkaline Phosphatase	84075	
☐ Bilirubin Direct	82248	
☐ Bilirubin Total	82247	
☐ C Reactive Protein (CRP Quant)	86140	
☐ Calcium Level Total	82310	
☐ CBC Hemogram (CBC)	85027	
☐ CBC with Differential (CBCD)	85025	
☐ Cholesterol Total*	82465	
☐ Creatinine Level	82565	
☐ Digoxin Level	80162	
☐ Ferritin	82728	
☐ Glucose Level	82947	
☐ Hemoglobin A1C (Glycated)	83036	
☐ HIV p24 Ag, HIV-1, 2 Ab Combo Screen	87389	
☐ Iron Level	83540	
☐ Lactate Dehydrogenase (LDH)	83615	
☐ Lead, Blood - *Sendout* (Labcorp)	83655	
☐ Magnesium Level	83735	
☐ Microalbumin/Creatinine Ratio, Urine	82043	
☐ Partial Thromboplastin Time (PTT)	85730	
☐ Phenytoin Level Total (Dilantin)	80185	
☐ Potassium Level	84132	
☐ Prostate Specific Antigen (PSA)	84153	
☐ Prothrombin Time (PT with INR)	85610	
☐ PSA Screen (Medicare)	G0103	
☐ Sedimentation Rate (ESR)	85652	
☐ Sodium Level	84295	
☐ T4 Total	84436	
☐ Thyroid Stimulating Hormone (TSH) Reflex will occur when TSH result is outside established normal range	84443 / 84439	
☐ Thyroxine Free (Free T4)	84439	
☐ TIBC w/Transferrin•	83450 / 83550	
☐ Triglycerides*	84478	
☐ TSH with Reflex Free T4	84443	
☐ Uric Acid	84550	
☐ Urinalysis with Culture, if indicated	87086	
☐ Urinalysis with Microscopic Urine Type: ☐ Clean Catch ☐ Cath ☐ In/Out	81001	
☐ Vitamin D 25 Hydroxy Level	82306	
☐ _____	_____	
☐ _____	_____	
☐ _____	_____	

MICROBIOLOGY CULTURES	CPT CODE	DIAGNOSIS CODE
Specimen Description: _____		
☐ Acid Fast Bacilli Culture w/AFB Smear	87116 / 87206 / 87015	
☐ Bronchoscopy Culture w/Smear	87070 / 87015 / 87205	
☐ Ear Culture w/Smear Aerobic	87070 / 87205	
☐ Eye Culture w/Smear Aerobic	87070 / 87205	
☐ Fluid Culture w/Anaerobes & Smear	87070 / 87205 / 87015 / 87075	
☐ Fungus Culture w/Smear	87102 / 87205	
☐ Genital Culture w/Smear	87070 / 87205	
☐ Respiratory Culture w/Smear	87070 / 87205	
☐ Skin Culture w/Smear	87070 / 87205	
☐ Stool Culture	87045 / 87046	
☐ Throat Culture	87070	
☐ Tissue Culture w/Anaerobes & Smear	87070 / 87176 / 87205 / 87075	
☐ Urine Culture ☐ Clean Catch ☐ In/Out Cath ☐ Foley	87086	
☐ Wound Culture w/Smear	87070 / 87205	
☐ Wound Culture w/Anaerobes & Smear	87075 / 87070 / 87205	
MICROBIOLOGY OTHER		
☐ 2019 Coronavirus SARS-CoV-2 FL	87635	
☐ *Chlamydia trachomatis by NAAT*	87491	
☐ *Clostridioides difficile by NAAT*	87493	
☐ Fecal Blood Test by IC	82274	
☐ Group A Streptococcus by NAAT (Throat)	87651	
☐ Group B Streptococcus by NAAT (Vaginal/Rectal)	87653	
☐ HIV Quantitative by NAAT (Viral Load)	87536	
☐ HSV 1 & 2 by NAAT	87529	
☐ Influenza A,B by NAAT	87502	
☐ *Neisseria gonorrhoeae by NAAT*	87591	
☐ Occult Blood Gastric Fluid	82271 / 83986	
☐ Occult Blood, Stool Non Neoplasm Screen x1	82272	
☐ Occult Blood, Stool x3 Neoplasm Screen	82270	
☐ RPR Qual by Latex Agglutination	86592	
☐ *Trichomonas vaginalis by NAAT*	87661	
☐ _____	_____	

☐ BASIC METABOLIC PANEL (BMP) Sodium, Potassium, Chloride, CO2, BUN, Glucose, Creatinine, Calcium, Osmolality•, AGAP•, Bun/Creat Ratio•	80048	
☐ COMPREHENSIVE METABOLIC PANEL (CMP) Sodium, Potassium, Chloride, CO2, BUN, Glucose, Creatinine, Total Protein, Calcium, Albumin, Bili Total, AST, Alk Phos, ALT, • AG Ratio, Osmolality•, AGAP•, Bun/Creat Ratio•	80053	
☐ ELECTROLYTE PANEL Sodium, Potassium, Chloride, CO2, AGAP•	80051	
☐ HEPATIC FUNCTION PANEL Total Protein, Albumin, Bili Total, AST, Alk Phos, Bili Direct, ALT, Bili Indirect, AG Ratio•	80076	
☐ HEPATITIS PANEL Hep A IgM, Hep B Core Ab, Hep B Core IgM, Hep Bs Ag, Hep C Ab	80074	
☐ LIPID PANEL* Trig, Chol, HDL C, LDL C Calc•, Chol/HDL, Non-HDL Chol, VLDL Chol	80061	
☐ RENAL FUNCTION PANEL Sodium, Potassium, Chloride, CO2, BUN, Glucose, Creatinine, Calcium, Albumin, Phosphorus, Osmolality•, AGAP•, Bun/Creat Ratio•	80069	

* Fasting Specimen Required • Calculation•

For a complete listing see the Ascension Sacred Heart Laboratory Online Test Menu

CLIA # 10D0271186

Total Tests Ordered: ☐

FOR LAB USE ONLY:

ACCT.# _____

Scheduling:
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Hours: Mon - Fri, 7:00a - 5:30p
Lab Order **Fax Server:** (850) 416-7337

Ascension Sacred Heart Pensacola

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ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER

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Collected By (First & Last Name): _____
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PATIENT'S FULL NAME: _____
Last First MI

DOB: ____/____/____ SSN: ____-____-____
PHONE #: (____) ____-____ SEX: M F
ADDRESS: _____
Insurance Carrier: _____
Policy #: _____ **Group #:** _____
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DOB: ____/____/____ **Relationship:** _____ Phone #: (____)____-_____
Insurance Authorization #: _____ Exp. Date: ____/____/____

PROVIDER'S FULL NAME: _____
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CLIA # 10D0271186

Total Tests Ordered: ☐