

TANDEM MASS SPECTROMETRY LABORATORY TEST REQUISITION 411-006G front / 11-17

PATIENT / SPECIMEN INFORMATION

PATIENT NAME - LAST, FIRST, MI		<input type="checkbox"/> M <input type="checkbox"/> F	SSN OR MRN	DATE OF BIRTH
RACE	DIAGNOSIS			
ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	

REFERRAL SOURCE

REQUESTING PHYSICIAN	REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE)		
PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE	PHONE NUMBER	FAX RESULTS FAX NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes	
REFERRING FACILITY			
FACILITY ADDRESS, CITY, STATE, ZIP - IF DIFFERENT FROM ABOVE	PHONE NUMBER	FAX RESULTS FAX NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes	
ADDITIONAL REPORTS TO			

BIOCHEMICAL GENETICS TESTS

TEST LIST	SPECIMEN REQUIREMENTS
25-HYDROXY VITAMIN D TOTAL (WITH D2 AND D3)(LC/MSMS)	2.0 ML WHOLE BLOOD-GOLD TOP SST OR RED TOP
PKU MANAGEMENT (PHE AND TYR BY LC/MSMS)	FILTER PAPER BLOOD SPOTS (MIN 2 BLOOD SPOTS/CARD)
DRUG SCREEN, URINE, COMPREHENSIVE (LC/MSMS)	20 ml RANDOM URINE (MIN 4mL)
DRUG SCREEN, URINE, CONFIRMATION (LC/MSMS)	20 ml RANDOM URINE (MIN 4mL)
CLINICAL URINE DRUG SCREEN W/ REFLEX TO CONFIRMATION (LC/MSMS)	20 ml RANDOM URINE (MIN 4mL)
LIST PRESCRIBED MEDICATIONS BELOW FOR DRUG SCREENING	
PROCEDURAL NOTES	
WHOLE BLOOD SPECIMENS	
• CENTRIFUGE SPECIMEN	
• SEPARATE PLASMA, SERUM	
• ALIQUOT SPECIMEN INTO POLYPROPYLENE TEST TUBE	
• FREEZE ALIQUOTTED SPECIMEN	
• SHIP FROZEN SPECIMEN ON DRY ICE	
URINE SPECIMEN	
• ALIQUOT 10.0 mL OF URINE INTO VACUETTE TEST TUBE	
RESULTS	
ALLOW 3-7 DAYS FOR SPECIMEN DELIVERY, PROCESSING AND RESULT INTERPRETATION	

CENTER FOR GENETIC TESTING AT SAINT FRANCIS USE ONLY

DATE RECEIVED	TIME	AMOUNT RECEIVED	ACCESSION NUMBER
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BILLING INFORMATION 411-006G back / 11-17

PAYMENT INFORMATION - INDICATE ONE

SELF PAY (Payment in Full from Patient or Guarantor)

Check or Money Order

<input type="checkbox"/> Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MC <input type="checkbox"/> OTHER			CARDHOLDER NAME - PRINT	ZIP CODE
ACCOUNT NUMBER	EXPIRATION DATE	SECURITY NO.	CARDHOLDER - SIGNATURE	

Payment for Medical Care: It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetic Testing at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetic Testing at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - MUST BE 18 YEARS OR OLDER TO SIGN _____ DATE _____

PARENT / LEGAL GUARDIAN - REQUIRED IF PATIENT IS LESS THAN 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT

ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER ()
EMPLOYER	WORK PHONE NUMBER ()
WITNESS - SIGNATURE	DATE

INSURANCE (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)
FRONT AND BACK COPY OF CARD, REFERRAL NUMBER (HMO), REFERRAL DATE AND AUTHORIZATION REQUIRED FOR THIRD PARTY BILLING

INSURED NAME	INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH	
PRIMARY CARE PHYSICIAN	EMPLOYER		
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	POLICY NUMBER	GROUP NUMBER
INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP CODE			
REFERRAL NUMBER	REFERRAL DATE	EFFECTIVE DATE	AUTHORIZATION NUMBER
MEDICARE NUMBER	MEDICAID NUMBER (OKLAHOMA ONLY)		

Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account: I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetic Testing at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetic Testing at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetic Testing at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - SIGNATURE _____ DATE _____

REFERRING FACILITY

FACILITY NAME	PHONE NUMBER ()	FAX NUMBER ()
BILLING ADDRESS	APPROVAL NUMBER - IF APPLICABLE	

OSDH

AUTHORIZATION NUMBER _____