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Practice Information:

Requesting Provider:

OB PANEL REQUISITION

Patient's Last Name:	First:	MI:	SSN#

Sex: M F	DOB:	Date / Time Collected:	MRN:	Relationship to Insured/Responsible Party: _____Self _____Spouse _____Dependent

Address of Patient:	Patient Phone:
City, State, and Zip Code:	Name of Insured/Responsible Party if not patient

Bill To:
- ☐ Medicare
- ☐ Medi-cal / Medicaid
- ☐ Patient
- ☐ Insurance (PPO)
- ☐ Other:_________________

Insurance Company Name (Please attached a copy of card front & back):	
Insurance ID#:	Group#:
Medi-Cal # / Medicaid #:	Medicare #:

DIAGNOSIS CODES (ICD CODES)

PANELS

Test	Tube
☐ Lipid Panel (fasting)	S
☐ Lipid Panel w/reflex DLDL	S
☐ Hepatic Panel	S
☐ Obstetric Panel w/reflex	Y,L,S

HEMATOLOGY

Test	Tube
☐ Hemoglobin	L
☐ Hematocrit	L
☐ CBC 3part Diff	L
☐ PT with INR	B
☐ PTT, Activated	B

OTHER TESTS

Test	Tube
☐ Albumin	S
☐ Alkaline Phosphatase	S
☐ ALT	S
☐ Antibody Screen	Y
☐ ABO Group & RH Type	Y,L
☐ AST	S
☐ Bilirubin, Direct	S
☐ Bilirubin, Total	S
☐ CA 125	S
☐ Cholesterol	S
☐ Creatinine	S
☐ Estradiol	S
☐ Ferritin	S
☐ FSH	S
☐ GGT	S
☐ Glucose Gestational Screen	GY
☐ Glucose Gestational Screen	GY
☐ Glucose Plasma	GY

OTHER TESTS

Test	Tube
☐ hCG, Total, Quant	S
☐ HDL-Cholesterol	S
☐ HE-4 Ovarion Cancer Monitoring	SR
☐ Hepatitis B Surface AG w/reflex Confirm	S
☐ HIV-1/2 AG/AB*4th w/reflex	S
☐ Homocysteine	S
☐ CRP HS	S
☐ Herpes I IgG	S
☐ Herpes II IgG	S
☐ Herpes I & II IgG	S
☐ Iron	S
☐ Iron, TIBC, %Sat	S
☐ LDLCholesterol Direct	S
☐ LH	S
☐ Parogesterone	S
☐ Prolactin	S
☐ RPR Screen w/reflex Titer	S
☐ RPR w/reflex Confirm	S
☐ Rubella	S
☐ Testosterone, Total	S
☐ Total Protein	S
☐ Triglycerides	S
☐ TSH	S
☐ TSH w/reflex T4 Free	S
☐ T4 Free	S
☐ UA Dipstick	U
☐ UA Dipstick w/reflex Microscopic	U
☐ UA Complete Dipstick&Microscopic	U
☐ Urea Nitrogen (BUN)	S

OTHER TESTS

Test	Tube
☐ Uric Acid	S
☐ Vitamin D, 25 Hydroxy	S
☐ Vitamin B 12	S

MICROBIOLOGY

Test	Tube
☐ Culture, Aerobic Bacteria	SW
☐ Culture, Aerobic Bacteria w/ Gram Stain	SW
☐ Culture, Genital	SW
☐ Culture, Streptococcus Group B	SW
☐ Culture, Urine Routine	STC
☐ Gram Stain	

- ***Addititional Charge for ID Susceptibility Studies***

HOLOGIC MOLECULAR APTIMA

Test	Tube
☐ Chlamydia & Gonorrhoease	U
☐ HPV	TP
☐ Trichomonas	TP

GENOTYPE

- ☐ DNA/RNA HIV
- ☐ Cytomegalovirus
- ☐ DNA / Hepatitis B
- ☐ DNA / HIV Reverse
- ☐ DNA / RNA Hepatitis C

PATHOLOGY

- ☐ Tissue Pathology

Anatomic Site	Procedure	Impression

Physician Signature:____ Date:____________________

Patient Signature:____ Date:____________________

Collector Signature:____ Date:____________________