



Practice Information

Patient Information

| | | | |
|------------|-------|---|-------|
| First Name | | Last Name | |
| DOB | SSN | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Address | | | |
| City | State | Zip | Phone |

ICD-10 Codes (common codes found on reverse side)

| | | | |
|--------|--------|--------|--------|
| Code 1 | Code 2 | Code 3 | Code 4 |
|--------|--------|--------|--------|

Specimen Information

| | |
|-------------------------|---|
| Collection Date: / / | Time : <input type="checkbox"/> AM <input type="checkbox"/> PM |
|-------------------------|---|

Billing Information (include copy of front/back of insurance card)

| | | | | |
|-------------------|------------------------|-----------------|-------------------------|-------------|
| Primary Insurance | Subscriber ID/Group ID | Name of Insured | Relationship to Insured | Insured DOB |
|-------------------|------------------------|-----------------|-------------------------|-------------|

| ORGAN OR DISEASE PANELS | ALPHABETICAL / COMBINATION TEST | ALPHABETICAL / COMBINATION TEST | PCR PANELS & MICROBIOLOGY |
|---|--|---|---|
| <input type="checkbox"/> 80048 Basic Metabolic Panel (8) <input type="checkbox"/> 80053 Comp Metabolic Panel (14) <input type="checkbox"/> 80051 Electrolyte Panel <input type="checkbox"/> 80076 Hepatic Function Panel (7) <input type="checkbox"/> 80061 Lipid Panel <input type="checkbox"/> 80069 Renal Function Panel | <input type="checkbox"/> 82040 Albumin <input type="checkbox"/> 84075 Alkaline Phosphatase <input type="checkbox"/> 84460 ALT (SGPT) <input type="checkbox"/> 82150 Amylase <input type="checkbox"/> 84450 AST (SGOT) <input type="checkbox"/> 82607 82746 B12 and Folate <input type="checkbox"/> 82247 Bilirubin, Total <input type="checkbox"/> 84520 BUN <input type="checkbox"/> 82310 Calcium <input type="checkbox"/> 82465 Cholesterol, Total <input type="checkbox"/> 82565 Creatinine <input type="checkbox"/> 82670 Estradiol <input type="checkbox"/> 82728 Ferritin <input type="checkbox"/> 83001 83002 FSH and LH <input type="checkbox"/> 82977 GGT <input type="checkbox"/> 82947 Glucose, Serum <input type="checkbox"/> 84703 hCG, Beta Subunit, Qual (Serum Pregnancy) <input type="checkbox"/> 83718 HDL Cholesterol <input type="checkbox"/> 83036 Hemoglobin A1C <input type="checkbox"/> 86701 HIV Screen <input type="checkbox"/> 86695 86696 HSV I, II, IgG, IgM <input type="checkbox"/> 83001 83002 Iron and IBC <input type="checkbox"/> 83615 LD <input type="checkbox"/> 83735 Magnesium | <input type="checkbox"/> 86308 Mononucleosis Test, Qual <input type="checkbox"/> 84100 Phosphorus <input type="checkbox"/> 84132 Potassium <input type="checkbox"/> 84144 Progesterone <input type="checkbox"/> 84146 Prolactin <input type="checkbox"/> 84153 / G0103 PSA <input type="checkbox"/> 86431 Rheumatoid Arthritis Factor <input type="checkbox"/> 86593 RPR <input type="checkbox"/> 85652 Sed Rate, Westergren <input type="checkbox"/> 84295 Sodium <input type="checkbox"/> 84403 Testosterone, Total <input type="checkbox"/> 84403 Testosterone Women/Children <input type="checkbox"/> 84436 Thyroxine (T4) <input type="checkbox"/> 84439 Thyroxine (T4), Free <input type="checkbox"/> 84478 Triglycerides <input type="checkbox"/> 84480 Triiodothyronine (T3) <input type="checkbox"/> 84443 TSH, 3rd generation <input type="checkbox"/> 84550 Uric Acid <input type="checkbox"/> 81003 Urinalysis <input type="checkbox"/> 82306 Vitamin D - 25 Hydroxy | <input type="checkbox"/> Upper Respiratory Panel <input type="checkbox"/> Covid 19 <input type="checkbox"/> Bordetella Pertussis/Parapertussis <input type="checkbox"/> Group A Strep <input type="checkbox"/> Gastrointestinal Panel <input type="checkbox"/> UTI Panel <input type="checkbox"/> Wound Panel Women's Health <input type="checkbox"/> Bacterial Vaginosis <input type="checkbox"/> Candida Vaginitis STD/STI <input type="checkbox"/> Leuko <input type="checkbox"/> Urogen <input type="checkbox"/> HSV, I, II |
| HEMATOLOGY <input type="checkbox"/> 85025 CBC w Diff w Plt <input type="checkbox"/> 85014 Hematocrit <input type="checkbox"/> 85018 Hemoglobin <input type="checkbox"/> 85049 Platelet Count <input type="checkbox"/> 85041 RBC Count <input type="checkbox"/> 85048 WBC Count <input type="checkbox"/> 82607 Differential/Total WBC Count <input type="checkbox"/> 82746 Folic Acid | | | MICROBIOLOGY <input type="checkbox"/> Urine Culture <input type="checkbox"/> Additional Cultures: _____ |

Patient Signature

I request and authorize Southern Lab Partners Laboratories to perform the designated test(s) on the DNA sample provided by me as well as provide clinical reporting. Assignment of Benefits: I hereby authorize the entry to bill my insurance company and receive payment from them in my behalf. I acknowledge, however, that I am responsible for payment on my account and any and all charges associated with its collection. I hereby authorize my insurance company to pay the entity directly for services rendered. Donor Signature: I certify that I provided my specimen to the collector, that I have not adulterated it in any manner, each specimen used was sealed in my presence and the information provided on this form and on the label affixed to each specimen is correct. I authorize the release of the results to the ordering clinician authorized client/representative, or prescribing/attending physician.

Patient Signature: _____ Date: _____

Provider Authorization

Physician Certification: I hereby request and authorize Southern Lab Partners Laboratories to utilize this information to perform the designated testing for the indicated patient. I certify that I have explained the testing to the patient indicated in this requisition form. I also certify that I will only use and disclose test results as permitted by law.

Physician Signature: _____ Date: _____