

Lab Test Requisition

Highlighted fields are required

Patient Information				Billing Method		Specimen Information	
Patient ID #				Inpatient	<input type="checkbox"/>	Outpatient	<input type="checkbox"/>
Last Name				Bill:	<input type="checkbox"/> Client	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other
First Name		MI		<i>Attach copy of insurance or complete section below</i>			Collected By
Address				Insurance Company			Lab Director or Ordering Physician
City		State		Plan type			
Phone		Zip		Group #			
Date of Birth	/	/	Age	Policy #	ICD-9 Codes		
Sex	Female	<input type="checkbox"/>	Male	Guarantor Name			

Client Information				Request Copy to Referring Physician			
Client ID #				Name			
Name				Address			
Address				City			
City		State		State		Zip	
Phone				Phone			
Fax				Fax			

✓	Molecular Amniotic Fluid	✓	Microbiology Amniotic Fluid
	Bacteria/ <i>Mycoplasma/Ureaplasma</i> by Endpoint PCR		<i>Mycoplasma/Ureaplasma</i> culture
			Aerobic culture
			Anaerobic culture
			Gram stain
✓	Chemistry Amniotic Fluid		
	Glucose concentration		
	Interleukin-6 concentration		

Additional Comments:	
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White Copy: Send with specimen to ProteoGenix

Yellow Copy: Retain for records