COFFEE REGIONAL MEDICAL CENTER
912–384–1900
Ext 4140
Gerson Paull, M.D., Laboratory Director
1101 Ocilla Road, Douglas, GA 31533

PHYSICIANS LABORATORY SERVICES
OB/GYN TEST REQUEST

Last Name ____ First Name ____ MI ____

DOB ____ ❑ M or ❑ F Race ____ Marital Status: ❑ M ❑ S ❑ D Social Security Number ____

Address ____ City ____ State ____ Zip ____

Bill to: ❑ Physician Client ❑ Medicare/Medicaid/Insurance **(Please attach copies of cards)**

Physician Name ____ **Signature** ____ **Date/Time** ____

Time and Date of Specimen Collection ____ Urine: ❑ Clean–catch ❑ Cath ❑ Voided

Priority: ❑ Routine ❑ Stat ❑ Call Results ❑ Fax Results

Medicare will pay only for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Medicare does not pay for tests for which documentation, including the patient record, does not support that the tests were reasonable and necessary. Medicare generally does not cover routine screening tests even if the physician considers the tests appropriate for the patient.

Diagnosis or ICD10 code (for each test)____

❑ OB Panel (80055)
- CBC/Diff
- Type & Screen
- RPR & Titer
- Rubella
- Hepatitis B Sur Ag

❑ HIV Screen/Confirmation (86703) (Permit Required)

❑ Cystic Fibrosis Screen (83891, 83901, 83893, 83896, 83912)

❑ Penta Screen (82677, 84702, 82105, 86336, 82397)

❑ Quad Screen (82105, 84702, 82667, 86336)

Gest Age Det by: ❑ LMP or ❑ Ultra or ❑ Day of LMP ____/____/____

____/____/____ **EDC** ____ **Patient Weight** ____ **Race** **Repeat Test?: ❑ Y ❑ N**

Insulin Dependent?: ❑ Y ❑ N History of Neural Tube Defect?: ❑ Y ❑ N

HEMATOLOGY	BACTERIOLOGY	CHEMISTRY	CHEMISTRY PROFILES
CBC/Diff (85025)	**C & S**	ALT (SGPT (84460)	**Basic Metabolic (80048)** (Na, K, Cl, CO2, Glu, BUN, Creat, Ca)
Ref Man. Diff (85023)	Gr. B Strep (87081)	AST (SGOT (84450)	
CBC / No Diff (85027)	HSV (87252)	B12 (82607)	**Comprehensive Metabolic (80053)** (Na, K, Cl, CO2, Glu, BUN, Creat, Ca, ALP, Alb TP, TBIL, ALT, AST)
Hgb/HCT (85661, 85112)	Throat (87070)	CA 125 (86304)	
Sed. Rate (85651)	Sputum (87070)	CEA (82378)	
Sickle Screen (85660)	Stool (87045)	Estradiol (82670)	**Electrolytes** (80051) (Na, K, Cl, CO2)
CLINICAL MICROSCOPY	Urine (87088)	Ferritin (82728)	**Hepatic Function (80076)** (TBIL, DBIL, TP, ALB ALP, AST, ALT)
Urinalysis / Micro (81001)	Wound (87070) (Aerobic/Anaerobic) **Site:**	Folate (82746)	
		FSH (83001)	**Lipid Analysis (80061)** (Chol, HDL, Trig, LDL, Calc)
SEROLOGY		Glucose (82947)	
ABO & RH (86900, 86901)		GDS (82951)	**Renal Function Panel (80069)** (Lytes, Glu, BUN, Crea, Ca, Alb, Phos)
ANA (86039)	GC/Chlamydia DNA Probe (87491, 87591)	GTT, 3 hr (82947)	
Antibody Screen (86850)		Hepatitis B Sur AG (87340)	**CYTOLOGY**
HCG, Quant. (84702)	Gram Stain (87205)	HSV 2 IgG Serum (86695)	Sure–Path Pap (88174)
Pregnancy, Serum (84703)	**MISCELLANEOUS TESTS**	Insulin (83525)	Thin–Prep Pap (88174)
Pregnancy, Urine (84703)	**Please List:**	Iron/TIBC (83550)	With HPV (87621)
RA (86430)		LH (83002)	With GC (87591)
RPR (Reflex Titer) (86592)		Progesterone (84144)	With Chlamydia (87491)
Reflex FTA (87285)		Prolactin (84146)	
		T4, Free (84439)	LMP:____
		TSH (84443)	
			Smoker Y or No
			Oral Contraceptives:

Date of Last Pap:____

Results:____

Has patient had any previous biopsy? Y or No

If Yes, Dates:____

Coffee Regional Medical Center

PHYSICIANS LABORATORY SERVICES
OB/GYN TEST REQUEST

Patient's Name: ______________________________ Date of Birth: _______________ SSN: ______________________

Emergency Contact:____ Phone: ________________________

I authorize consent for Coffee Regional Medical Center (CRMC) to perform diagnostic testing and authorize CRMC to release any medical information and documents to Blue Cross Blue Shield, Medicare, Medicaid or other insurance companies for the purpose of completing an insurance claim. I hereby assign to and authorize the direct payment to Coffee Regional Medical Center of any and all insurance or other benefits payable to me for any services rendered. I acknowledge that I am solely responsible for any charges incurred for services provided by Coffee Regional Medical Center. I accept full responsibility for all charges not covered by insurance of for which payment is denied.

I authorize Coffee Regional Medical Center, its service providers (including service providers contacting me about obtaining potential financial assistance for my accounts(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my accounts(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre–recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

Additional Provision for Minors: I acknowledge and verify that I am the legal guardian or custodian of minor/incapacitated patient and can legally give legal consent under Georgia Medical Consent Law.

HIPAA Consent/Privacy Notice:
I understand that Coffee Regional Medical Center will use and disclose protected health information about me as a patient or about the patient on whose behalf I am giving this consent to carry our treatment, payment or health care operations and will limit other disclosures as described in the Notice of Privacy Practices ("Notice") of coffee Regional Medical Center. I understand that I have the right to receive a paper copy of this notice upon request by calling (912) 384–1900 ext. 4549 or by visiting our Web Site www.coffeeregional.org.

INDEPENDENT CONTRACTORS: Some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omission of any such independent contractors.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

Date:________________ Time:_______________ AM / PM

____ (SEAL) ____________________ ____________________
Patient /Guarantor /Authorized Person Signature Relation to Patient Patient Phone Number

Company / Agency____Phone Number_____________________

Employee Witness____ Title______________________________