CRMC COFFEE REGIONAL MEDICAL CENTER
912−384−1900
Ext 4140
William Titman, M.D., Laboratory Director
1101 Ocilla Road, Douglas, GA 31533

PHYSICIANS LABORATORY SERVICES
OB/GYN TEST REQUEST

3PO

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

LAST, FIRST MNAME ROOM−BED s
V1234 t 04/30/2008 M1234 **m**
04/30/2008 *00M 07D*

Date of Last Pap:_____

Results:_____

Has patient had any previous biopsy? Y or No

If Yes, Dates:_____

COFFEE REGIONAL MEDICAL CENTER

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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_____

LAST, FIRST MNAME ROOM−BED s
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