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

OUTPATIENT LABORATORY TEST REQUEST

3PO

This form is to be utilized when patient is referred to outpatient laboratory facility!

DIAGNOSIS−

Diagnosis must be included for each test ordered.
All tests ordered must be medically justified.

Physician Offices− For the most updated form please visit www.coffeeregional.org and print from the "For Our Physicians" link.

HEMATOLOGY

TEST	CPT	DIAGNOSIS
CBC/Plt/Auto Diff (Reflex Manual Diff)	85025 85007 85027	
CBC / No Diff	85027	
Hemoglobin	85018	
Hematocrit	85014	
Protime / INR	85610	
PTT	85730	
Retic Count	85045	
Sed Rate	85651	
Sickledex	85660	

URINALYSIS / MICROSCOPY

TEST	CPT	DIAGNOSIS
Occult Blood, Screen	82270	
Occult Blood	82272	
O & P, includes Giardia Ag/Crypto	87328 87329	
Urinalysis / Micro	81001	

BACTERIOLOGY

TEST	CPT	DIAGNOSIS
Gram Stain	87205	
Culture and Sensitivity		
AFB	87118	
Sputum	87070	
Stool	87045	
Throat	87070	
Urine	87088	
Wound *	87070	
* Includes Anaerobic / Aerobic		
*Site:		
Other Source	87070	
Site:		

MISCELLANEOUS BACTERIOLOGY

TEST	CPT	DIAGNOSIS
C. Difficile	87803	
Chlamydia Screen	87320	
Giardia Antigen	87329	
Group A Strep	87880	
Rotazyme	86759	
RSV	87807	
Chlamydia	87491	
GC PCR, Urine	87591	

OTHER TESTS, PLEASE SPECIFY

	DIAGNOSIS

CHEMISTRY PROFILES

TEST	CPT	DIAGNOSIS
Basic Metabolic	80048	
Na,K,Cl,CO2,Glucose,BUN,Creatinine,Ca		
Comp. Metabolic	80053	
Na, K, Cl, CO2, Albumin, T. Bilirubin, Calcium, Creatinine, Glucose, Alkaline Phos. T. Protein, ALT, AST, BUN		
Electrolytes	80051	
Na, K, Cl, CO2		
Hepatic Function	80076	
Total & Direct Bilirubin, total Protein, Albumin, Alkaline Phosphatase, ALT & AST		
Lipid Analysis	80061	
Cholesterol, HDL Cholesterol, Triglycerides & LDL Calculation		
Renal Profile	80069	
Na, K, Cl, CO2, Albumin, Calcium, Creatinine, Glucose, Phosphorus, BUN		

THERAPEUTIC DRUG ASSAYS

Time of Med:

TEST	CPT	DIAGNOSIS
Acetaminophen	82003	
Digoxin	80162	
Phenobarbital	80184	
Phenytoin	80185	
Tegretol	80156	
Theophyline	80198	
Valproic Acid	80164	

SEROLOGY / BLOOD BANK

TEST	CPT	DIAGNOSIS
ABO Group	86900	
Rh Type	86901	
Antibody Screen	86850	
ANA	86039	
ASO, Reflex Titer	86060	
CRP	86140	
HCG, Quant.	84702	
HIV, Permit Req.	86703	
H. Pylori	83013	
Mono Test	86308	
Pregnancy, Serum	84703	
Pregnancy, Urine	84703	
Rheumatoid Factor	86430	
RPR, Reflex Titer	86592	
Rubella	86762	

CHEMISTRY TEST, SINGLE

TEST	CPT	DIAGNOSIS
Amylase	82150	
Alk. Phosphatase	84075	
ALT (SGPT)	84460	
AST (SGOT)	84450	
B12	82607	
Bilirubin, Total	82247	
Bilirubin, Direct	82248	
BUN	84520	
Calcium	82310	
CEA	82378	
CK, Total	82550	
CK, Mass MB	82553	
Cholesterol	82465	
Creatinine	82565	
Ferritin	82728	
Folate	82746	
FSH	83001	
GGT	82977	
Glycated Hgb	83036	
Glucose	82947	
GTT − 1 hour	82950	
GTT − 2 hour	82951	
Iron Panel (Iron/TIBC)	83540 83550	
LH	83002	
Lipase	83690	
Magnesium	83735	
Phosphorus	84100	
Potassium	84132	
Protein, Total	84155	
PSA, Screen	G0103	Z12.5
PSA	84153	
Sodium	84295	
Triglycerides	84478	
Troponin I	84484	
T4, Free	84439	
uTSH	84443	
Uric Acid	84550	

FLUID ANALYSIS

Source:

TEST	CPT	DIAGNOSIS
Cell Count	89051	
Culture	87070	
Crystal Exam	89060	
Glucose	82945	
Gram Stain	87205	
Protein	84157	
Uric Acid	84560	

DATE **TIME** **PHYSICIAN SIGNATURE**

1 Copy to CRMC − 1 copy to Lab − 1 copy to Physician

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Rev. 09/26/2022

COFFEE REGIONAL MEDICAL CENTER

OUTPATIENT LABORATORY 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_____

LAST, FIRST MNAME ROOM−BED s
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