



912-384-1900
Ext 4140

Gerson Paull, M.D., Laboratory Director
1101 Ocilla Road, Douglas, GA 31533

OUTPATIENT LABORATORY TEST REQUEST



3 PO

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			CHEMISTRY PROFILES			CHEMISTRY TEST, SINGLE		
TEST	CPT	DIAGNOSIS	TEST	CPT	DIAGNOSIS	TEST	CPT	DIAGNOSIS
CBC/Plt/Auto Diff (Reflex Manual Diff)	85025 85007 85027		Basic Metabolic	80048		Amylase	82150	
CBC / No Diff	85027		Na, K, Cl, CO ₂ , Glucose, BUN, Creatinine, Ca			Alk. Phosphatase	84075	
Hemoglobin	85018		Comp. Metabolic	80053		ALT (SGPT)	84460	
Hematocrit	85014		Na, K, Cl, CO ₂ , Albumin, T. Bilirubin, Calcium, Creatinine, Glucose, Alkaline Phos. T. Protein, ALT, AST, BUN			AST (SGOT)	84450	
Protime / INR	85610		Electrolytes	80051		B12	82607	
PTT	85730		Na, K, Cl, CO ₂			Bilirubin, Total	82247	
Retic Count	85045		Hepatic Function	80076		Bilirubin, Direct	82248	
Sed Rate	85651		Total & Direct Bilirubin, total Protein, Albumin, Alkaline Phosphatase, ALT & AST			BUN	84520	
Sickledex	85660		Lipid Analysis	80061		Calcium	82310	
URINALYSIS / MICROSCOPY			Cholesterol, HDL Cholesterol, Triglycerides & LDL Calculation			CEA	82378	
TEST	CPT	DIAGNOSIS	Renal Profile	80069		CK, Total	82550	
Occult Blood, Screen	82270		Na, K, Cl, CO ₂ , Albumin, Calcium, Creatinine, Glucose, Phosphorus, BUN			CK, Mass MB	82553	
Occult Blood	82272					Cholesterol	82465	
O & P, includes Giardia Ag/Crypto	87328 87329					Creatinine	82565	
Urinalysis / Micro	81001					Ferritin	82728	
BACTERIOLOGY			THERAPEUTIC DRUG ASSAYS			SEROLOGY / BLOOD BANK		
TEST	CPT	DIAGNOSIS	Time of Med:	TEST	CPT	DIAGNOSIS	Glycated Hgb	83036
Gram Stain	87205			Acetaminophen	82003		Glucose	82947
Culture and Sensitivity				Digoxin	80162		GTT - 1 hour	82950
AFB	87118			Phenobarbital	80184		GTT - 2 hour	82951
Sputum	87070			Phenytoin	80185		Iron Panel	83540
Stool	87045			Tegretol	80156		(Iron/TIBC)	83550
Throat	87070			Theophylline	80198		LH	83002
Urine	87088			Valproic Acid	80164		Lipase	83690
Wound *	87070						Magnesium	83735
* Includes Anaerobic / Aerobic							Phosphorus	84100
*Site:			SEROLOGY / BLOOD BANK				Potassium	84132
Other Source	87070		TEST	CPT	DIAGNOSIS		Protein, Total	84155
Site:			ABO Group	86900			PSA, Screen	G0103 Z12.5
MISCELLANEOUS BACTERIOLOGY			Rh Type	86901			PSA	84153
TEST	CPT	DIAGNOSIS	Antibody Screen	86850			Sodium	84295
C. Difficile	87803		ANA	86039			Triglycerides	84478
Chlamydia Screen	87320		ASO, Reflex Titer	86060			Troponin I	84484
Giardia Antigen	87329		CRP	86140			T4, Free	84439
Group A Strep	87880		HCG, Quant.	84702			uTSH	84443
Rotazyme	86759		HIV, Permit Req.	86703			Uric Acid	84550
RSV	87807		H. Pylori	83013		FLUID ANALYSIS		
Chlamydia	87491		Mono Test	86308		Source:		
GC PCR, Urine	87591		Pregnancy, Serum	84703		TEST	CPT	DIAGNOSIS
OTHER TESTS, PLEASE SPECIFY			Pregnancy, Urine	84703		Cell Count	89051	
		DIAGNOSIS	Rheumatoid Factor	86430		Culture	87070	
			RPR, Reflex Titer	86592		Crystal Exam	89060	
			Rubella	86762		Glucose	82945	
						Gram Stain	87205	
						Protein	84157	
						Uric Acid	84560	

DATE

TIME

PHYSICIAN SIGNATURE

PO_9034_EFR

Rev. 02/19/2025

1 Copy to CRMC - 1 copy to Lab - 1 copy to Physician

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 or 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 _____