



New London Hospital
273 County Road
New London, NH 03257

Laboratory Requisition

Date: ___ / ___ / ___ STAT SPEC

PATIENT INFORMATION			ACCT #
NAME (last)	(first)	DOB	PHYSICIAN INFORMATION
		SEX <input type="checkbox"/> M <input type="checkbox"/> F	SIGNATURE
ADDRESS		PHONE #	PRINT NAME
CITY/STATE/ZIP			FAX TO
I authorize NLH to release to CMS and/or my insurance company any information needed to consider payment for services rendered. I understand that I am responsible for all services not paid for by that policy.			CALL TO
PATIENT SIGNATURE			OTHER PHYSICIAN INFORMATION
SPECIMEN COLLECTED BY _____ DATE & TIME _____			
LAB USE ONLY - SAMPLES RECEIVED BY _____ INDICATE # OF SAMPLES REC'D.			
LAVENDER ___ LT. BLUE ___ GREEN ___ GOLD ___ RED ___ PINK ___ GRAY ___ URINE ___			

DIAGNOSIS INFORMATION

COMPLIANCE GUIDELINES DICTATE THAT THE DIAGNOSIS MEET MEDICAL NECESSITY REQUIREMENTS. PLEASE PROVIDE A DIAGNOSIS THAT SUPPORTS EACH TEST ORDERED.

DX1	DX3
DX2	DX4

LEGEND: RF = REFLEX TEST AT ADDITIONAL CHARGE **ABN SIGNATURE MAY BE REQUIRED

ALBUMIN	GLUCOSE TOL. (50 gms) 1 hr	PANEL, acute hepatitis ^{RF}	T3 UPTAKE**
ALK PHOS	GLUCOSE TOL. _____ hr	PANEL, basic metabolic	T4 FREE**
ALT	GLUCOSE TOL. Gestational	PANEL, comprehensive metabolic	T4 TOTAL**
AMMONIA	GLUCOSE, fasting**	PANEL, EBV (IGG IGM NA EA)	TSH**
AMYLASE	HCG serum (qual)	PANEL, electrolytes	TESTOSTERONE, TOTAL
ANA w/reflex	HCG serum (quant)	PANEL, hepatic (liver)	TESTOSTERONE, TOTAL & FREE
ANTIBODY SCREEN ^{RF}	HEMATOCRIT**	PANEL, lipid** (fast 12-14 hr)	TISSUE TRANSGLUTAMINASE
AST	HEMOGLOBIN**	PANEL, RAST Non seasonal	TRANSFERRIN SATURATION
BILIRUBIN, DIRECT	HEMOGLOBIN A1C**	PANEL, RAST seasonal	TRIGLYCERIDES** (fast 12-14 hr)
BILIBUBIN, TOTAL	HEP. A Ab, Total w/reflex IGM ^{RF}	PHLEBOTOMY - indicate cut off	URIC ACID
BLOOD TYPE	HEP. Bc Ab, Total	H&H _____ schedule with lab	VALPROIC ACID
BNP	HEP. Bs Ab	PHOSPHORUS	VANCOMYCIN - PEAK
BUN	HEP. C Ab	PLATELET COUNT**	VANCOMYCIN - TROUGH
CA 125	HEP.C VIRAL RNA PCR QUANT	POTASSIUM	VITAMIN B12
CALCIUM	HIV (consent form required)	PROLACTIN	VITAMIN D, 25-OH
CBC/no diff**	HOMOCYSTEINE	PROTEIN ELECTROPHORESIS	WBC**
CBC/with diff** ^{RF}	HSV IGG 1&2	PROTEIN, TOTAL	URINE TESTS URINALYSIS - CHECK ONE ___ DIPSTICK ONLY ___ DIPSTICK & MICROSCOPIC ___ MICROSCOPIC ONLY ___ CULTURE IF INDICATED ^{RF} ** ___ CLEAN CATCH ___ CATH ___ OTHER
CEA	IGE - TOTAL	PSA - diagnostic**	
CHLORIDE	INSULIN	PSA - screening**	
CHOLESTEROL**	IRON**	PSA, TOTAL & FREE	
CK	IRON/TIBC**	PT**	
CO2	LDH	PTT**	
CORTISOL	LEAD ___ CAP ___ VENOUS	PTH INTACT	
CREATININE	LH	RETIC**	HCG QUALITATIVE, URINE
CROSSMATCH ^{RF} # UNITS _____	LITHIUM	RF SCREEN ^{RF}	MICROALBUMIN, random urine
CRP, Cardio	LYME DISEASE, IGG, IGM ^{RF}	RPR	OTHER: SPECIFY
CRP, Quant	MAGNESIUM	RUBELLA	
DIGOXIN**	METHYLMALONIC ACID	RUBEOLA	
DILANTIN (Phenytoin)	MONO	SED RATE	
FERRITIN**	FSH	SODIUM	
FOLATE	GGT	TEGRETOL (carbamazepine)	

STANDING ORDERS; CHECK OFF TESTS NEEDED

FREQUENCY _____ **DATE EXPIRES (NOT TO EXCEED 12 MONTHS)** _____