



Arkansas Children's Hospital
 REFERRED PATIENT REQUISITION FORM
 LABORATORY - NEWBORN TESTING

SPECIMEN: (1) Type (circle the correct specimen type below):
Urine Serum Plasma Whole Blood

(2) **Collection Date:** _____
 (3) **Collection Time:** _____
 (4) **Weight at Collection:** _____

ADH Card (HL-11) - Skip to 2nd Tier Testing

FOLLOW-UP TESTING FOR METABOLIC DISORDERS (Account Type = LABNB)

Mother's First Name: _____ Patient's Birthdate: _____ Phone #: _____ Patient's Address: _____	Patient Name: _____ (ACH USE) Patient 8 Digit ACH Account#: _____ (ACH USE) Patient 6 Digit ACH Unit#: _____ Sex: _____ Medicaid Number: _____
Referring Institution Referral# Referring /Ordering MD Referring MD License# Physician NPI# Referring MD (Qualchoice # (If Applicable) Referring MD UPIN: Attending MD: Primary Care MD: Primary Care MD Medicaid #:	Guarantor _____ Phone# _____ Guarantor's Relationship to Patient _____ Guarantor's Address _____ Insurance / Other Coverage Name _____ Phone# _____ Insured's Name _____ Insured DOB _____ Insured's Relationship to Patient _____ Group Name and # _____ Insured's Policy# _____

X	LAB MNEMONIC	DESCRIPTION	CPT	DIAGNOSIS CODE
	OAS	ORGANIC ACID ANALYSIS - URINE, 5ML, FROZEN WITHIN 1 HOUR	83919	796.6
	AC	ACYLCARNITINE ANALYSIS - PLASMA, 1 ML, GREEN TOP, FROZEN WITHIN 1 HOUR	82017	796.6
	CARN	FREE & TOTAL CARNITINE - PLASMA, 1ML, GREEN TOP, FROZEN WITHIN 1 HOUR	82379	796.6
	AAQPL	AMINO ACID ANALYSIS - PLASMA, 1ML, GREEN TOP, FROZEN WITHIN 1 HOUR	82139	796.6
	P/T	PHENYLALANINE/TYROSINE - PLASMA, 1 ML, GREEN TOP, REFRIGERATE	84510; 84030	270.1 - Monitoring 796.6 abnormal screen (CIRCLE ONE DX)
	AAQUR	AMINO ACID ANALYSIS - URINE, 5ML, FROZEN WITHIN 1 HOUR	82139	796.6
	GALT	GALACTOSE - 1- PHOSPHATE URIDYL TRANSFERASE (GALT ENZYME) - WHOLE BLOOD, 3 ML, GREEN OR PURPLE TOP, REFRIGERATE	82775	796.6
	BIO	SERUM BIOTINIDASE ASSAY - SERUM, 1 ML, GOLD TOP, FROZEN WITHIN 1 HOUR	82261	796.6
	HCYS	PLASMA TOTAL HOMOCYSTEINE - PLASMA OR SERUM, 1 ML, RED, GOLD, GREEN OR PURPLE TOP, REFRIGERATE WITHIN 1 HOUR	83090	796.6
	FT4	SERUM FREE T4 - PLASMA OR SERUM, 1 ML, GREEN OR GOLD TOP	84439	796.6
	T4	SERUM TOTAL T4 - PLASMA OR SERUM, 1 ML, GREEN OR GOLD TOP	84436	796.6
	TSH	SERUM TSH - PLASMA OR SERUM, 1 ML, GREEN OR GOLD TOP	84443	796.6
	HGB ELEC	HEMOGLOBIN ELECTRO - WHOLE BLOOD, 1 ML, PURPLE TOP	83020;83021	796.6
	CAH3	CAH3 STEROID PANEL (17OPH, CORTISOL, ANDROSTENEDIONE) - WHOLE BLOOD, 1 ML, PURPLE TOP	82157 82533 83498	796.6
	CFTR	CFTR MUTATION ANALYSIS - WHOLE BLOOD, 1 ML, PURPLE OR GREEN TOP	CF ORDER SET	796.6

FOR ADH USE ONLY - 2ND TIER TESTING (Account Type = LABADHNB)

Patient Name: _____ Patient Birthdate: _____ Patient Sex: _____
 Mother's First Name: _____

X	LAB MNEMONIC	DESCRIPTION	DIAGNOSIS CODE
	NB CAH3	STEROID PROFILE - ADH Card (HL-11)	796.6
	CFTRNB	CFTR MUTATION ANALYSIS - ADH Card (HL-11)	796.6

FOR ANY OTHER BASIC LAB TESTS OR STANDARD PANELS, PLEASE USE YOUR LOCAL PROVIDER

Contact Person: _____ Fax Results #: _____

Address to Mail Results: _____

NOTE: ORDER WILL NOT BE PROCESSED WITHOUT THE APPROPRIATE INFORMATION COMPLETED AND THE PHYSICIAN'S SIGNATURE AFFIXED.

The undersigned physician certifies that the ordered tests are medically necessary for the diagnosis and treatment of the patient.

Physician Signature: _____ Date: _____

Physician Name Printed: _____

If the patient is coming to the hospital for the test, have patient bring the completed form with them;
 OR If mailing the specimen, include the completed form and mail to: **Clinical Laboratory / Arkansas Children's Hospital
 800 Marshall, Slot 820; Little Rock, AR 72202**



REF.PT.REQ.NBSC

October 3, 2008

