



Arkansas Children's Hospital  
REFERRED PATIENT REQUISITION FORM  
LABORATORY

Patient Name: \_\_\_\_\_  
Patient 8 Digit ACH Account#: \_\_\_\_\_  
Patient 6 Digit ACH Unit#: \_\_\_\_\_  
Sex: \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Mother's First Name: \_\_\_\_\_  
Patient's Birthdate: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_  
  
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 #: \_\_\_\_\_  
Insurance / Other Coverage Address: \_\_\_\_\_  
  
Insured's Name: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Insured's Relationship to Patient: \_\_\_\_\_  
Group Name and #: \_\_\_\_\_  
Insured's Policy #: \_\_\_\_\_

**SPECIMEN: (1) Type (circle the correct specimen type below):**  
**Whole Blood**   **Plasma**   **Body Fluid**   **Serum**   **Tissue**  
**Spinal Fluid**   **Stool**   **Swab**   **Urine**   **Other:** \_\_\_\_\_  
**(2) Collection Date:** \_\_\_\_\_  
**(3) Collection Time:** \_\_\_\_\_

**MARK THE APPLICABLE TESTS AND WRITE IN THE APPROPRIATE DIAGNOSIS CODE BESIDE TESTS - All orders for tests must include the diagnosis/medical reason for the test. This must be an ICD-9 Diagnosis Code (5-digit code). Do not use "rule out" diagnoses and avoid using "V" codes.**

**BLOOD, SERUM AND/OR PLASMA**

X	OE	Description	CPT	Dx	X	OE	Description	CPT	Dx	X	OE	Description	CPT	Dx
	ALB	Albumin	82040			DIL	Dilantin	80185			P	Phosphorus	84100	
	ALKP	Alkaline Phosphatase	84075			DPT	Diphtheria	86648			PNEUMPRE	Pneumo Pre/each	86317	
	SGPT	ALT	84460			DBILI	Direct Bilirubin	82248			PNEUMPOST	Pneumo Post/each	86317	
	ANA	ANA (With Reflex) (includes AntiDNA)	86039			LYTES	Electrolyte Panel*	80051			K	Potassium	84132	
	ANAWOREF	ANA TITER (W/out Reflex)	86039			FT4	Free T4	84439			PREG	Pregnacy, Serum	84703	
	SGOT	AST	84450			GGT	GGT	82977			PT	Prothrombin Time	85610	
	BMPF	Basic Metabolic Panel (Ca++, Total)	80048			GLU	Glucose	82947			RAST	Rast, Each Antigen	86003	
	BUN	BUN	84520			LFT	Hepatic Function Panel*	80076			RFP	Renal Function Panel*	80069	
	CA	Calcium	82310			HCV	Hepatitis C antibody	86803			ESR	Sed Rate	85651	
	CBC	CBC (includes Diff)				HIV	HIV Antibody	86703			NA	Sodium	84295	
		Manual	85007			IGA	IGA	82784			RPR	Syphillis RPR, Qual	86592	
		Automated	85027			IGE	IGE	82785			T4	T4	84436	
	C3	C3 Complement	86160			IGG	IGG	82784			FK506	Tacrolimus (FK506)	80197	
	C4	C4 Complement	86160			IGM	IGM	82784			TEG	Tegretol	80156	
	C50	CH50 / Complement 50	86162			LP	Lipid Panel *	80061			TET	Tetanus	86774	
	CR	Creatinine	82565			MG	Magnesium	83735			TBILI	Total Bilirubin	82247	
	CYCAWB	Cyclosporin	80158			METH	Methotrexate	80299			TP	Total Protein	84155	
	EBVPCR	EBV PCR Quantitative	87799			MONO	Mono	86308			TSH	TSH	84443	
						PTT	Partial Thrombin Time	85730			UA	Urinalysis	81001	
						PHEN	Phenobarbital	80184			VALP	Valproic Acid	80164	

**OTHER TESTS**

X	OE	Description	CPT	Dx	X	OE	Description	CPT	Dx	X	OE	Description	CPT	Dx
	VCHL	Chlamydia Culture	87710			CR	Urine Creatinine	82570			OP	Ova & Parasite	87015	
	BPCR	B-pertussis PCR	87798			U	Urine Culture	87088					87210	
	SS	Strep Culture	87081			S	Stool Culture	87045					87209	
	SL	Strep Antigen	87880					87046			GIAR	Giardia/Crypto EIA Test	87328	
													87329	

**TESTS NOT LISTED ABOVE - INCLUDE CPT AND DESCRIPTION**

Contact Person: \_\_\_\_\_ Fax Results #: \_\_\_\_\_ Phone 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, rather than for screening purposes.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Name Printed: \_\_\_\_\_

**FAX THIS COMPLETED FORM TO: ACH OUTPATIENT TESTING at 501-364-3578**

Additionally: **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**

\* Centers for Medicare & Medicaid Services (CMS) approved panels:

<b>Hepatic Function 80076</b> Albumin 82040 Total Bilirubin 82247 Direct Bilirubin 82248 Alkaline Phosphatase 84075 Total Protein 84155	<b>Electrolyte 80051</b> Sodium 84295 Potassium 84132 Chloride 82435 CO2 82374	<b>Basic Metabolic (Calcium,Total) 80048</b> Calcium 82310    CO2 82374 Sodium 84295    Glucose 82947 Potassium 84132    BUN 84520 Chloride 82435    Creatinine 82565	<b>Lipid 80061</b> Triglycerides 84478 Cholesterol 82465 HDL Cholesterol 83718	<b>Renal 80069</b> Sodium 84295    BUN 84520 Potassium 84132    Creatinine 82565 Chloride 82435    Calcium 82310 CO2 82374    Phosphorus 84100 Glucose 82947    Albumin 82040
--	--	---	---	--



December 31, 2007

