

**SARASOTA MEMORIAL HOSPITAL – OUTPATIENT LABORATORY SERVICES**

For Draw Station locations,  
Call: (941) 917-1169

Information: (941) 917-1169  
Courier Pick-Up: (941) 780-4520  
Beeper: (941) 333-4655

FAX: (941) 917-2570

**REFERRED BY:** \_\_\_\_\_ **Coll. Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Coll. Time** \_\_\_\_\_ am / pm **Patient #** (Lab use only) \_\_\_\_\_  
**Collected by:** \_\_\_\_\_  
 **STAT Priority**       **Urgent**  
**Copy to:** \_\_\_\_\_ **Call to:** \_\_\_\_\_ **FAX to:** \_\_\_\_\_

**PATIENT INFORMATION:**

\_\_\_\_\_  
**Last Name**                      **First Name**                      M. Init.                      **Sex**                      **Date of Birth (MM/DD/YY)**                      **SS#**

\_\_\_\_\_  
**Street Address**                      **City**                      **State**                      **Zip Code**                      **Home Phone**

\_\_\_\_\_  
**INSURANCE COMPANY NAME & ADDRESS**                      **POLICY HOLDER AND POLICY NUMBER**

**DIAGNOSIS / CLINICAL HX / ICD-9 CODES (REQUIRED)**                      **PHYSICIAN SIGNATURE**

**Attention Ordering Physician:** For any patient or any payor (including Medicare and Medicaid) that has a medical necessity requirement, you should only order those tests which are medically necessary for the diagnosis and treatment of the patient. Use the Advanced Beneficiary Notice provided on the last page for any orders that do not meet medical necessity requirements. **Tests listed below in red have medical necessity requirements.**

ORGAN OR DISEASE ORIENTED PANELS				MISCELLANEOUS TESTS	
Electrolytes (NA, K, CL, CO2)					
Basic Metabolic Panel (NA, K, CL, CO2, Glu, BUN, Creat, Calcium)					
Comp. Metabolic Panel (NA, K, CL, CO2, Glu, BUN, Creat, Calcium, Alk. phos, SGOT, SGPT, T. Bili, T. Prot, Alb)					
<b>Lipid Panel (Chol, Trig., HDL Cholesterol)</b>					
<b>Hepatic Function Panel (Alb., Tot &amp; Direct Bili, Alk. phos., SGOT, SGPT, T. Protein)</b>					
<b>Renal Function Panel (NA, K, CL, CO2, BUN, Creat., Calcium, Phos, Alb.)</b>					
<b>Hepatitis Acute Panel (Hep C Ab, Hep B Surface Ag, Hep B Core IgM, Hep A IgM)</b>					
CHEMISTRY TESTS				HEMATOLOGY – COAGULATION TESTS	
Albumin	<b>Iron w/TIBC</b>	<b>T4, Total</b>	Vancomycin – Pre (trough)		
Alk phosphatase	<b>LDH</b>	<b>T7 (Total T4, T3 Uptake)</b>	Vancomycin – Post (peak)		
Amylase	Lipase	<b>TSH (Ultrasens.)</b>	HEMATOLOGY – COAGULATION TESTS		
BUN	<b>Magnesium</b>	<b>Total Protein</b>	<b>CBC w/DIFF &amp; PLT</b>		
<b>CA-125</b>	<b>Neonatal Bilirubin w/fract.</b>	<b>Uric Acid</b>	<b>Hemogram (CBC &amp; plt – NO diff)</b>		
<b>Calcium</b>	Phosphate	<b>Vitamin B12</b>	<b>Hemoglobin &amp; Hematocrit (H&amp;H)</b>		
Cardio CRP (high sensitivity)	<b>Potassium</b>	24 HOUR URINE COLLECTION		<b>Platelet Count</b>	
<b>CEA</b>	Protein Electrophoresis	Creatinine Clearance		<b>Reticulocyte Count</b>	
<b>Cholesterol</b>	<b>PSA – Screening</b>	<b>Total Protein, Urine</b>		<b>ESR (Sed Rate)</b>	
CPK	<b>PSA – Diagnostic: DX: _____</b>	Other: _____			
Creatinine	<b>PSA – Free &amp; Total: DX: _____</b>	THERAPEUTIC DRUGS		<b>Protime (PT) w/INR</b>	
<b>Ferritin</b>	SGOT (AST)	Depakene (Valproic Acid)		<b>APTT (PTT)</b>	
<b>Folic Acid</b>	SGPT (ALT)	<b>Digoxin</b>			
<b>Glycohemoglobin (HgbA1C)</b>	<b>T3 Uptake</b>	Dilantin		Cell Count – Fluid – Source: _____	
<b>Glucose</b>	<b>T3 Total</b>	Lithium		Crystal Exam – Fluid Source: _____	
<b>Iron</b>	<b>T4, Free</b>	Tegretol			
SEROLOGY – IMMUNOLOGY		MICROBIOLOGY		URINALYSIS	
Pregnancy Screen (serum)	<b>Source</b>		Influenza Rapid A&B		Urinalysis w/reflex microscopic
HCG Quantitative	Spec #1			RSV, Rapid Antigen (with reflex DFA)	U/A – Reflex Culture if indicated
	Spec #2			Urine Culture – Source? _____	<b>Occult Blood – Screen</b>
<b>Hep. A IGM</b>	Spec #3			Legionella Antigen	<b>Occult Blood – Complete Diagnosis: DX: _____</b>
<b>Hep. B Surf AG</b>	<b>Test Name</b>		Strep Pneumo Antigen		
<b>Hep. B Core IGM</b>	<b>Routine Culture</b>	<b>#1</b>	<b>#2</b>	<b>#3</b>	<b>DRUG SCREENS</b>
<b>Hep. C AB</b>	Fungus Culture				Urine Drugs of Abuse – Legal
<b>HIV Antibody</b>	AFB Culture				<b>Urine Drugs of Abuse – Non-Legal</b>
ANA <input type="checkbox"/> w/Reflex	Viral Culture				Blood Alcohol
Monospot		Affirm (G. vag. Trich, Candida)			
<b>Rheumatoid Factor</b>		Vaginal Beta Strep Screen			
<b>RPR</b>		Chlamydia/GC DNA Probe			
Rubella		Beta Strep A Screen (Throat)			
Rubeola (Measles)		Sputum C&S			
Varicella					



# ADVANCE BENEFICIARY NOTICE (ABN)



Patient's Name: \_\_\_\_\_ Medicare # (HICN): \_\_\_\_\_  
 Sarasota Memorial Hospital 1700 S. Tamiami Trail Sarasota FL 34239 (941) 917-9000

Patient Acct #: \_\_\_\_\_ Date of Service: \_\_\_\_\_

**NOTE: You need to make a choice about receiving these laboratory tests.**

We expect that Medicare will not pay for the tests listed below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for these tests for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**. •Ask us to explain, if you don't understand why Medicare probably won't pay. •Ask us how much these items or services will cost you, in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

**Option 1. YES. I want to receive these laboratory tests.**  
*I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.*

**Option 2. NO. I have decided not to receive these items or services.**  
*I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of patient or person acting on patient's behalf**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of hospital representative**

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0586 Form No. CMS-R-131-G (June 2002)

**SARASOTA MEMORIAL HOSPITAL**



**DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR**

PATIENT NAME
DATE OF BIRTH
DOCTOR:
<b>PLACE PATIENT ID LABEL HERE</b>