Cincinnati Children's Hospital Medical Center

ANCILLARY ORDER FORM

LABORATORY
Specimen Pick-Up / Fax Network Inquiries / Lab Results
(513) 636-7328 - 1-800-653-5516
TEST REFERRAL CENTER - (513) 636-4461 - Fax (513) 636-3918
RADIOLOGY
Radiology Scheduling/Results - (513) 636-4251
Radiology Orders Main Campus - Fax (513) 636-3004
Radiology Orders Test Referral Center - Fax (513) 803-1111

☐ Routine ☐ Stat
☐ Patient Presented For Lab Draw
☐ Specimen Only

PATIENT NAME _____
LAST FIRST MI

ADDRESS _____

SEX: M ___ F___ DATE OF BIRTH _____ PHONE

CCHMC
MEDICAL RECORD # _____

BILL: ☐ Patient ☐ Client

www.cincinnatichildrens.org/svc/dept-div/clinical-labs

COLLECTION INFORMATION:
*** Required**

Draw Date _____ **Draw Time** _____

INS OR NETWORK 1

Subs. ID		Group No.	
Ins. Street	City	State	Zip
Phone		Subs. DOB	
Subs. Name/ Rel.			
Subs. Address			

INS OR NETWORK 2

Subs. ID		Group No.	
Ins. Street	City	State	Zip
Phone		Subs. DOB	
Subs. Name/ Rel.			
Subs. Address			

DIAGNOSIS / ICD-9 CODE

_____

ORDERING PHYSICIAN

_____ DATE _____

PHONE / BEEPER # _____ FAX # _____

FAX / CALL RESULTS TO:

SPECIMEN TUBES:

☐ SST (gold) ☐ RED (plain) ☐ LAV (EDTA)
☐ BLU (citrate) ☐ GRN (Li Hep) ☐ GRN (Na Hep) ☐ Other _____

TOTAL TESTS ORDERED ☐

LABORATORY BLOOD:

Acylcarnitine
___ Plasma
___ Dried Blood Spot(s)
___ Albumin*
___ ALT (SGPT)*
___ AST (SGOT)*
___ Amino Acids Serum
___ Amylase*
___ ANA (Titer If Positive)
___ Autoantibody Screen
___ ASO
___ Bile Acid
___ Bilirubin, Conjugated*
___ Bilirubin, Unconjugat.*
___ BMP*
___ B.U.N.*
___ C Reactive Protein*
___ Calcium*
___ CBC (incl. plat)*
___ CBC, Diff., Plat*
___ Cholesterol*
Chromosome Analysis (Bld)
___ Routine
___ High Resolution
___ CMP* (Comprehensive Metabolic Panel)
___ Coenzyme Q10
___ Compl. Profile
___ Creatinine*
___ EBV Profile
___ Electrolytes*
___ Fragile X
___ Fibrinogen*
___ Glucose*
___ Hemoglobin A_1C
___ Hepatic Panel*
___ HGB Electrophor.
___ HGB S Level
___ Hep A Ab (Total)
___ Hep A IgM
___ Hep Bc Ab
___ Hep Bs Ab
___ Hep Bs Ag
___ Hep C Ab
___ IgE
___ IgG Subclasses
___ Iron*
___ LDH*
Lead Level
___ Venous
___ Capillary
___ Lipid Profile
___ Magnesium*
___ Mono Spot*
___ Newborn Screen
___ Phosphorus*
___ Potassium*
___ Pregnancy Serum*
___ PT*
___ aPTT*
___ Renal Profile*
___ Retic Count
___ Sed Rate*
___ Sodium
___ SPP
___ T3
___ T Uptake
___ T4 (free)
___ TIBC
___ TSH
___ Triglycerides*
___ Uric Acid*

URINE
___ Amino Acids
___ Metabolic Screen
___ Organic Acids
___ Pregnancy Urine*
___ Urinalysis*
___ Urine CX CC
___ Urine CX CATH
___ Urine Comp. Drug Screen
___ Urine - Drugs of Abuse Screen

SPECIAL TESTS
___ Sweat Chloride
Appointment Required (513) 636-3200
___ Spec. Hematology Test
Appointment Required (513) 636-4685

STOOL
___ C. Diff Toxin
___ Occult Blood
Ova & Parasites
___ Ova & Par.
___ Giardia Crypto DFA
___ Rotovirus
___ Stool Culture

DRUG LEVELS
___ Acetaminophen*
___ Carbamazepine* (Tegretol)
___ Cyclosporin
___ Digoxin*
___ Felbamate
___ Gabapentin (Neurontin)
___ Imipramine
___ Lamotrigine (Lamictal)
___ Levetiracetam (Keppra)
___ Lithium*
___ Mephobarbital (Mebaral)
___ Oxcarbazepine (Trileptal)
___ Phenobarbital*
___ Phenytoin*
___ Primidone
___ Salicylate*
___ Sirolimus
___ Tacrolimus
___ Topiramate
___ Valproic Acid* (Depakote)
___ Zonisamide

MICROBIOLOGY

_____
Specify Specimen Source (Required)
___ Blood Culture
___ Chlam DNA
___ GC DNA
___ Influenza A/B, Antigen
___ RSV Antigen
___ ORSA Culture
___ Pertuss, Cx & FA
___ Resp. Culture
___ Strep Culture (throat only)
___ Wound Culture
___ Urine Culture
___ CX CC
___ CX Cath

RADIOLOGY
___ Abdomen ___ Forearms
___ Airway ___ Hand
___ Ankle ___ Hips
___ Bone Age ___ Sinuses
___ Chest ___ Spine
___ Elbow ___ (specify)
___ Foot ___ Wrist

MOLECULAR PATHOLOGY

_____
Specify Specimen Source (Required)
Adenovirus
___ Quant ___ Qual
___ B. pertussis/parapertussis
BK Virus
___ Quant ___ Qual
Cytomegalovirus
___ Quant ___ Qual
___ Enterovirus
Epstein-Barr Virus
___ Quant ___ Qual
___ Herpes Simplex Virus 1/2
Human Herpesvirus 6
___ Quant ___ Qual
___ Parvovirus B19
___ Respiratory Panel
___ Toxoplasma gondii
___ Varicella-Zoster Virus
___ HIV RNA PCR (sendout)

*Available for STAT testing

NOTICE: ORDER INDIVIDUAL COMPONENTS

OTHER TESTS / X-RAYS / APPOINTMENT TIMES / SPECIAL INSTRUCTIONS _____

Special Preparation: ☐ None ☐ No Food or Drink for _____ Hours ☐ Other _____

Name of Provider _____
Date and Time _____
Contact Name _____
Information Provided _____
_____
CCHMC Initials _____

MEDICAL NECESSITY REGULATIONS: At the government's request, the Clinical Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid, will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.

☐ Check here if patient signed completed ABN. ☐ Patient requests insurance to be billed.

Rev. 04/10

LABORATORY BLOOD

Autoantibody Screen
ANA ASMA APCA
ATA MITO LKM

BMP*
(Basic Metabolic Panel)
(Na, K, Cl, CO2,
BUN, creat, CA, gluc)

CMP* (Comprehensive
Metabolic Panel)
(Na, K, Cl, CO2, BUN,
creat, gluc, CA, alb,
total prot, alk phos,
alt, ast, bili u, bili c)

Comp. Profile
(1Q, C2, C3, C4,
C5, C6, C7, C8,
C9, Properdin,
C4 BP, C1 Inhib)

EBV Profile
IgG, IgM, EBNA

Electrolytes*
(Na, K, Cl, CO_2)

Hepatic Panel*
(alb, tot prot, AST,
ALT, alk phos, bili c,
bili u, glob, a/g ratio)

Lipid Profile
Cholesterol
Triglycerides
HDL
LDL

Renal Profile*
(Na, K, CO2, CL,
bun, creat)

SPP
(IgA, IgG, IgM,
C3, C4, Transf,
CRP, Alb)

MOLECULAR PATHOLOGY

Respiratory Panel
Influenza A, B, RSV,
Parainfluenza 1, 2, 3
Human Metapneumovirus