Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

☐ STAT

HEAVY METAL REQUISITION DEMOGRAPHICS FORM

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name	First	MI
SS #	Birth Date Age	Sex ☐ M ☐ F
ACC #	Patient ID	

BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)

BILL TO: ☐ Client ☐ Patient ☐ Medicare ☐ Medicaid ☐ Other Insurance

Patient Address

City County State Zip

Telephone

THE STATE OF OHIO REQUIRES THE FOLLOWING INFORMATION WHEN ORDERING LEAD, CADMIUM, MERCURY OR ARSENIC

Ethnicity: ☐ Unknown (;Z) ☐ Hispanic (;H) ☐ Non-Hispanic (;N) ☐ Other (;O)

Race: ☐ Unknown (;Z) ☐ White (;W) ☐ Black (;B) ☐ Asian (;A) ☐ Multi-Racial (;M) ☐ Native American (;N) ☐ Other (;O)

Name of guardian/parent (if patient is under 16 years of age)

Please complete the following section when a copy of insurance card (front and back) is not provided.

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address City State Zip

SECONDARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address City State Zip

WORKER'S COMP: Claim #: Date of Injury:

DIAGNOSIS CODE (REQUIRED)

1. _____ 2. _____

3. _____ 4. _____

CLIENT INFORMATION

PHYSICIAN SIGNATURE (REQUIRED)

Date collected: ___/___/___ Time: _____

Collected by: _____

Specimen Type: ☐ **Whole Blood** ☐ Venous (;V) or ☐ Capillary (;C)

☐ **Urine** ☐ Random or ☐ 24 hour / volume _____ ml

Physician Signature Date / Time

Physician Print Name

Address

City State Zip

Phone UPIN

☐ Send additional report

Physician: _____

Address: _____

City, State, Zip: _____

EMPLOYER INFORMATION (REQUIRED)

Patient's Employer (or NA;)

Address (or ;NA)

City (or ;NA) State (or ;NA) Zip (or ;NA)

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

MEDICAL NECESSITY NOTICE

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INDICATE TESTS REQUESTED

	ASB	Arsenic, Blood		UARSND	Arsenic, Urine
	CADM	Cadmium, Blood		U24CAD	Cadmium, Urine
	LEAD	Lead, Blood		ULEAD	Lead, Urine
	MERC2	Mercury, Blood		UMERC3	Mercury, Urine
	HEVMET	Heavy Metals Screen, Blood		UTXMCD	Toxic Metal Panel & Cadmium, Urine 24 Hr
X	HMDEMO	Heavy Metals Demographics		UTXMCR	Toxic Metal Panel & Cadmium, Random Urine
	PBZPP	Lead/ZPP OSHA Panel		UTXMTL	Toxic Metal, Urine 24 Hr
	ZPP	Zinc Protoporphyrin			

WHITE: Laboratory Copy YELLOW: Billing Copy PINK: Client Copy