3165 McKelvey Road, Suite 110
Bridgeton, Mo 63044
Phone: (314) 743-3748
Fax: (314) 743-3749
www.aimlaboratories.com
CLIA#: 26D1101943
COLA#: 21428
Lab Director: Guihua M. Cao, MD

PRACTICE INFORMATION REQUIRED

Practice Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

PHYSICIAN INFORMATION REQUIRED

Physician Name: _____ NPI: _____
Physician Name: _____ NPI: _____
Physician Name: _____ NPI: _____

CLINICAL LABORATORY REQUISITION FORM

1 PATIENT INFORMATION — REQUIRED

First Name: _____ Last Name: _____ Date of Birth: _____

Gender: ☐ M ☐ F Bill Type: ☐ Insurance ☐ Self-Pay ☐ Client Bill ATTACH A COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

2 COLLECTION INFORMATION — REQUIRED

Date: _____ Time: _____ ☐ AM ☐ PM Collector Initials: _____

3 DIAGNOSIS (ICD-10) CODES (MEDICALLY NECESSARY) — REQUIRED

ICD-10 Codes: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

4 TEST ORDER — SELECT ONE OR MORE (REQUIRED)

DISEASE PANELS: Use "SST" tubes for collection off all Disease Panel specimens (Full Panel Details on the Reverse Side)

☐ Acute Hepatitis Panel ☐ Basic Metabolic Panel ☐ Complete Metabolic Panel ☐ Electrolyte Panel ☐ Hepatic Function Panel ☐ Lipid Panel ☐ Renal Function Panel
☐ STD Panel - SST and Urine Required ☐ Thyroid Panel

HEMATOLOGY: Use "LAV" tubes for collection off all Hematology specimens unless indicated otherwise on test below in "RED"

☐ CBC W/ Retic
☐ CBC W/O Differential
☐ Complete CBC W/ Auto Diff
☐ Hematocrit
☐ Hemoglobin
☐ Manual Differential
☐ Platelet Count
☐ PTT Activated - Light Blue
☐ PT/INR - Light Blue
☐ SED Rate (ESR)
☐ WBC Count
☐ WBC Differential

COMBINATION TESTS: Use "SST" tubes for collection off all Combination Test specimens unless indicated otherwise on test below in "RED"

☐ ALT (SGPT)
☐ Amylase
☐ Antinuclear Antibodies ANA
☐ AST (SGOT)
☐ BUN
☐ CCP Antibodies
☐ CEA
☐ Cholesterol, Total
☐ Cortisol
☐ C-Peptide, Serum
☐ C-Reactive Protein (CRP)
☐ C-Reactive Protein (HSCRP)
☐ Creatine Kinase (CK)
☐ Creatinine
☐ Estradiol
☐ Ferritin
☐ Folate
☐ GGT
☐ FSH
☐ Glucose, Serum
☐ HCG, Beta Subunit, Qual
☐ HDL Cholesterol
☐ Hemoglobin, A1C - LAV
☐ HEP A Antibody, IGM
☐ HEP B Surface Antibody
☐ HEP B Surface Antigen
☐ HEP C Antibody
☐ HEP C Virus (HCV), QUAN, RNA, PCR
☐ Herpes Simplex Virus (HSV)
☐ HSV 1&2 Specific Antibodies IgG
☐ HIV 1&2 Antibodies
☐ Iron
☐ Iron Panel
☐ Lipase
☐ LH
☐ Magnesium
☐ Phosphorus
☐ Potassium
☐ PROBNP
☐ Progesterone
☐ Prolactin
☐ PSA
☐ PTH Intact
☐ Rheumatoid Arthritis Factor
☐ RPR
☐ Rubella Antibodies, IgG
☐ Testosterone
☐ Thyroxine (T4)
☐ Thyroxine, Free (T4)
☐ T3 Uptake
☐ Triiodothyronine (T3)
☐ Triiodothyronine, Free (T3)
☐ TSH, 3rd Generation
☐ Troponin - Green LH
☐ Uric Acid
☐ Urinalysis - URN
☐ Vitamin B12
☐ Vitamin D, 25-Hydroxy

DRUG TEST LEVELS: Use "RED" tubes for collection off all drug level specimens

☐ Carbamazepine (Tegretol) ☐ Digoxin ☐ Dilantin ☐ Lithium ☐ Phenobarbital ☐ Valporic Acid (Depakote) ☐ Vancomycin

MICROBIOLOGY:

☐ Aerobic Bacterial Culture ☐ CT/NG, NAA ☐ Genital Culture Routine ☐ Ova and Parasites ☐ Throat Beta-Hemolytic Strep Culture, Group A ☐ Wound Culture
☐ Blood Culture, Routine BCM ☐ Fungus Culture ☐ Gram Strain ☐ Stool Culture ☐ Upper Respiratory Culture, Routine ☐ Urine Culture, Routine

☐ SPECIAL TEST REQUST: Write in the box to the right

7 PATIENT ACKNOWLEDGEMENT — REQUIRED

This specimen was provided voluntarily for analysis and I authorize AIM Laboratories to process, bill and provide results. I agree to the declarations and terms in the patient acknowledgment and irrevocable assignment of benefits on the back of this form.

Patient Signature: X _____ Patient Name: _____
Date: _____ Date of Birth: _____

8 AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT — REQUIRED

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

Provider Signature:
X _____
Date: _____

DISEASE PANEL BREAKOUTS

ACUTE HEPATITIS PANEL

Hepatitis A Antibody IGM • Hepatitis B Surface Antibody • Hepatitis B Surface Antigen • Hepatitis C Antibody

BASIC METABOLIC PANEL (BMP)

• Albumin • BUN • Calcium • Chloride • CO2 • Creatinine • eGFR • Glucose • Potassium

COMPLETE METABOLIC PANEL (CMP)

• Albumin • ALP • ALT • AST • BUN • Calcium • Chloride • CO2 • Creatinine • eGFR • Glucose • Potassium • Sodium
• Total Bilirubin • Total Protein

ELECTROLYTE PANEL

• Chloride • Potassium • Sodium

HEPATIC FUNCTION PANEL (LFT)

• BUN • Calcium • CO2 • Creatinine • Glucose • Potassium • Sodium

LIPID PANEL

• Cholesterol • HDL • LDL • HDL/LDL Ratio • Triglyceride

RENAL FUNCTION PANEL (KFT)

• Albumin • BUN • Calcium • Chloride • Creatinine • Glucose • Sodium • Phosphorus • Potassium

STD PANEL

• Chlamydia/Gonorrhea (CT/NG) • Hepatitis A Antibody IGM • Hepatitis B Surface Antibody • Hepatitis B Surface Antigen
• Hepatitis C Antibody • HIV • Herpes Simplex Virus 1&2 • Syphilis (RPR)

THYROID PANEL

• T3 Uptake • Thyroxine (T4) • Triiodothyronine (T3) • TSH

PATIENT ACKNOWLEDGMENT AND IRREVOCABLE ASSIGNMENT OF BENEFITS

The information provided on this form and on the label affixed to the specimen cup is accurate. The specimen identified on this form is my own. I have not adulterated it in any way. I am voluntarily submitting this specimen for analysis by my healthcare provider and/or third party lab. I authorize the lab to release the results of this test to the ordering healthcare provider. The lab is authorized to bill my insurance provider, or any payer, whether fully insured or self-insured, and I will irrevocably assign any payment of benefits, claims, rights, and interests related to the services my healthcare provider performed against any payer. I further authorize the lab and my healthcare provider to release to my insurance provider any medical information necessary to process this claim.

I acknowledge that AIM Laboratories may be an out-of-network facility/provider with my insurance provider. I am also aware that in some circumstances my insurance provider may send the payment directly to me. I agree to endorse the insurance check and forward it to AIM Laboratories within 15 days of receipt as payment towards the lab services provided by AIM. I acknowledge that I am responsible for any amounts =not covered by my insurer including any deductibles and co-payments/co-insurance. I understand that AIM Laboratories may use my specimen and any testing performed on that specimen for research and development so long as the information has been de-identified pursuant to law. I am aware that all AIM Laboratories Privacy Practices can be found at www.aimlaboratories.com.

 # Medical Necessity Documentation: Per Novitas Solutions LCD L35006 criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment, and documented by the clinician in the patient's medical record.