

2811 Tieton Drive
 Yakima, WA 98901

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 yvm.testcatalog.org

LAB REQUISITION

QUALITY CHECK (HOSPITAL USE ONLY)

INITIALS _____ DATE _____ TIME _____

ACCEPT REJECT

PATIENT LABEL

PATIENT INFORMATION

NAME (LAST) REQUIRED		NAME (FIRST) REQUIRED		MIDDLE	SEX F <input type="checkbox"/> M <input type="checkbox"/>	DATE OF BIRTH REQUIRED	
ADDRESS				CITY	STATE	ZIP	
PHONE NUMBER		DIAGNOSIS CODE(S) REQUIRED					

PROVIDER INFORMATION

PROVIDER NAME REQUIRED	PHONE NUMBER REQUIRED	FAX NUMBER REQUIRED
PROVIDER SIGNATURE REQUIRED	FACILITY REQUIRED	
	<input type="checkbox"/> COMPREHENSIVE MENTAL HEALTH <input type="checkbox"/> YAKIMA UROLOGY <input type="checkbox"/> GOOD SAMARITAN <input type="checkbox"/> UNION GOSPEL MISSION <input type="checkbox"/> YAKIMA PEDIATRICS <input type="checkbox"/> OTHER _____	

***** PLEASE ATTACH OR PROVIDE COMPLETE BILLING INFORMATION ON THE NEXT PAGE *****

NOTE: DIAGNOSIS INFORMATION MUST BE SUBMITTED FOR EACH TEST ORDERED. MEDICARE/MEDICAID GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS AND WILL ONLY PAY FOR TESTS DEEMED MEDICALLY NECESSARY FOR THE TREATMENT/DIAGNOSIS OF THE PATIENT.

DATE & TIME COLLECTED REQUIRED	<input type="checkbox"/> AM <input type="checkbox"/> PM	CONTAINERS SUBMITTED ***ALL SPECIMENS MUST BE LABELED WITH 2 PATIENT IDENTIFIERS***	RED	GREEN	YELLOW	LAV.	PINK	BLUE	STOOL	URINE	SWAB
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CHEMISTRY PANELS	CHEMISTRY (CONTINUED)	THERAPEUTIC DRUGS
<input type="checkbox"/> BASIC METABOLIC PANEL (NA, K, CL, CO ₂ , GLU, BUN, CRE, CA, AGAP, GFR) CX8P	<input type="checkbox"/> SODIUM NA	<input type="checkbox"/> ACETAMINOPHEN ACET
<input type="checkbox"/> COMPREHENSIVE METABOLIC PANEL (CX8P, TP, ALB, TBIL, AST, ALKP, ALT) CMP	<input type="checkbox"/> THYROID STIMULATING HORMONE TSH	<input type="checkbox"/> DIGOXIN DIG
<input type="checkbox"/> ELECTROLYTES PANEL (NA, K, CL, CO ₂) LYTE	<input type="checkbox"/> THYROID STIMULATING HORMONE, REFLEX <input type="checkbox"/> TSHR	<input type="checkbox"/> GENTAMICIN <input type="checkbox"/> RANDOM <input type="checkbox"/> TROUGH <input type="checkbox"/> PEAK
<input type="checkbox"/> HEPATIC FUNCTION PANEL (ALB, TP, TBIL, AST, ALKP, ALT) HFP	<input type="checkbox"/> THYROXINE, FREE (T4) FT4	<input type="checkbox"/> LITHIUM LI
<input type="checkbox"/> RENAL PANEL (CX8P, ALB, PHOS) RENP	<input type="checkbox"/> TRIIODOTHYRONINE, FREE (T3) FT3	<input type="checkbox"/> PHENOBARBITAL PBARB
<input type="checkbox"/> LIPID PANEL (CHOL, TRIG, HDL, LDL) LIPID	<input type="checkbox"/> TROPONIN I TROP	<input type="checkbox"/> PHENYTOIN (DILANTIN) DILN
	<input type="checkbox"/> UREA NITROGEN BUN	<input type="checkbox"/> SALICYLATE SALI
	<input type="checkbox"/> URIC ACID URIC	<input type="checkbox"/> TEGRETOL (CARBAMAZEPINE) TEG
		<input type="checkbox"/> VALPROIC ACID (DEPAKOTE) VPA
		<input type="checkbox"/> VANCOMYCIN <input type="checkbox"/> RANDOM <input type="checkbox"/> TROUGH <input type="checkbox"/> PEAK

CHEMISTRY	COAGULATION & HEMATOLOGY	URINE TESTS
<input type="checkbox"/> ALT ALT	<input type="checkbox"/> COMPLETE BLOOD COUNT CBC	<input type="checkbox"/> CHLAMY/GONORRHOEAE/TRICHOMONAS, PCR CHGCT
<input type="checkbox"/> ALBUMIN ALB	<input type="checkbox"/> COAGULATION SURVEY CS	<input type="checkbox"/> CREATININE, RANDOM UCRR
<input type="checkbox"/> ALKALINE PHOSPHATASE (ALP) ALKP	<input type="checkbox"/> D-DIMER DIM	<input type="checkbox"/> DRUG SCREEN, URINE DSU
<input type="checkbox"/> AMYLASE AMY	<input type="checkbox"/> FIBRINOGEN FIBRIN	<input type="checkbox"/> MICROALBUMIN UMALB
<input type="checkbox"/> AST AST	<input type="checkbox"/> HEMOGLOBIN & HEMATOCRIT HNHL	<input type="checkbox"/> URINALYSIS, COMPLETE URC
<input type="checkbox"/> B-TYPE NATRIURETIC PEPTIDE BNP	<input type="checkbox"/> HEMOGRAM (CBC W/O DIFF) HGML	<input type="checkbox"/> URINALYSIS, CULTURE IF INDICATED <input type="checkbox"/> URCIF
<input type="checkbox"/> BILIRUBIN, DIRECT DBIL	<input type="checkbox"/> HEPARIN (ANTI-FACTOR Xa) 1UFH	
<input type="checkbox"/> BILIRUBIN, TOTAL TBIL	<input type="checkbox"/> HEPARIN, LOW MOLECULAR WEIGHT LMWH	
<input type="checkbox"/> C-REACTIVE PROTEIN CRP	<input type="checkbox"/> PLATELET COUNT 1PLT	
<input type="checkbox"/> CALCIUM, TOTAL CA	<input type="checkbox"/> PROTHROMBIN TIME (INR) PTINR	
<input type="checkbox"/> CARBON DIOXIDE, TOTAL CO2	<input type="checkbox"/> PARTIAL THROMBOPLASTIN TIME (PTT) PTT	
<input type="checkbox"/> CHOLESTEROL, TOTAL CHOL	<input type="checkbox"/> SEDIMENTATION RATE WSR	
<input type="checkbox"/> CORTISOL, RANDOM CORT		
<input type="checkbox"/> CK, TOTAL CK		
<input type="checkbox"/> CREATININE CRE		
<input type="checkbox"/> ETHANOL (ETHYL ALCOHOL) ETOH		
<input type="checkbox"/> FOLATE FOL		
<input type="checkbox"/> GAMMA GLUTAMYL TRANSFERASE (GGT) GGT		
<input type="checkbox"/> GLUCOSE GLU		
<input type="checkbox"/> IRON FET		
<input type="checkbox"/> LACTATE DEHYDROGENASE (LDH) LD		
<input type="checkbox"/> LIPASE LIPA		
<input type="checkbox"/> MAGNESIUM MG		
<input type="checkbox"/> PHOSPHORUS PHOS		
<input type="checkbox"/> POTASSIUM K		
<input type="checkbox"/> PROTEIN, TOTAL TP		

CHEMISTRY	STOOL TESTS	VIROLOGY
	<input type="checkbox"/> CLOSTRIDIODES DIFFICILE TOXIN, EIA <input type="checkbox"/> CDIFF	<input type="checkbox"/> COMPREHENSIVE RESPIRATORY PANEL, PCR RSPCR
	<input type="checkbox"/> ENTERIC PARASITE PANEL, PCR EPPAN	<input type="checkbox"/> HEPATITIS PROFILE HEPP
	<input type="checkbox"/> FECAL OCCULT BLOOD FOB	<input type="checkbox"/> HIV 1&2 ANTIBODY <input type="checkbox"/> HIVCOM
	<input type="checkbox"/> OVA & PARASITE EXAM OP	<input type="checkbox"/> INFLUENZA A&B, EIA INFLU
		<input type="checkbox"/> MONONUCLEOSIS MONO
		<input type="checkbox"/> RUBELLA (IMMUNE STATUS) RUBE
		<input type="checkbox"/> SARS-CoV-2, PCR (COVID-19) COV19

CHEMISTRY	MICROBIOLOGY	OTHER TESTS/COMMENTS
	<input type="checkbox"/> AEROBIC (WOUND) CULTURE [†] WNDC	
	<input type="checkbox"/> ANAEROBIC CULTURE [†] ANERC	
	<input type="checkbox"/> FLUID CULTURE (LARGE VOLUME) [†] FLDC	
	<input type="checkbox"/> RESPIRATORY CULTURE [†] RESPC	
	<input type="checkbox"/> THROAT STREP SCREEN THRSS	
	<input type="checkbox"/> URINE CULTURE URNC	
	<input type="checkbox"/> CATH <input type="checkbox"/> CLEAN CATCH	
	†SOURCE: _____	

= REFLEX TESTING AUTOMATICALLY PERFORMED IF INDICATED

BILLING INFORMATION

PLEASE ATTACH A COPY OF BILLING INFORMATION CONTAINING RESPONSIBLE PARTY'S INSURANCE TO THE OUTREACH LAB REQUISITION. YOU MAY ATTACH THE BILLING SHEET PROCURED BY YOUR FACILITY OR FILL THE FOLLOWING FORM OUT WITH THE REQUIRED INFORMATION. MISSING OR INCOMPLETE BILLING INFORMATION MAY RESULT IN DELAY OF TESTING.

MEDICARE

MEDICAID

CLIENT

INSURANCE

PATIENT

PRIMARY

SUBSCRIBER NAME	SOCIAL SECURITY #
RELATIONSHIP TO PATIENT	PHONE #
INSURANCE COMPANY	
GROUP #	MEMBER/SUBSCRIBER #
ADDRESS OF RESPONSIBLE PARTY	
PRIMARY CARE PHYSICIAN	

SECONDARY

SUBSCRIBER NAME	SOCIAL SECURITY #
RELATIONSHIP TO PATIENT	PHONE #
INSURANCE COMPANY	
GROUP #	MEMBER/SUBSCRIBER #
ADDRESS OF RESPONSIBLE PARTY	
PRIMARY CARE PHYSICIAN	

SUPPLEMENTAL INFORMATION

PLEASE REFER TO THE TEST CATALOG YVM.TESTCATALOG.ORG FOR GUIDANCE ON SPECIMEN COLLECTION, SPECIMEN STABILITY, REFERENCE RANGES, AND CPT CODES. THE OUTREACH LAB REQUISITION IS COMPRISED OF COMMONLY ORDERED TESTS AND DOES NOT INCLUDE THE FULL CATALOG OF IN-HOUSE TESTING OFFERED BY YAKIMA MEMORIAL. REFER TO THE TEST CATALOG WHEN ORDERING TESTS THAT ARE NOT LISTED ON THE REQUISITION. PLEASE NOTE THAT THE TEST CATALOG IS COMPRISED OF TESTING OFFERED BY BOTH YAKIMA MEMORIAL HOSPITAL AND MAYO CLINIC LABORATORIES. THE PERFORMING LABORATORY SHOULD BE REVIEWED WHEN SELECTING TESTING NOT LISTED ON THE REQUISITION FORM.

FAILURE TO PROVIDE REQUIRED INFORMATION MAY RESULT IN DELAY OF TESTING. THOROUGHLY REVIEW REQUISITION BEFORE SUBMITTING TO MINIMIZE RISK OF DELAY.

