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LAB REQUISITION

QUALITY CHECK (HOSPITAL USE ONLY)

INITIALS DATE TIME

PATIENT LABEL

(509)-746-2315 (509)-452-5328			INITIALS DATE TIME		
wyvm.testcatalog.org			□ ACCEPT □ REJECT		
			PATIENT INFORMATION		
NAME (LAST)	NAM	E (FIRST			SEX DATE OF BIRTH
REQUIRED					F M REQUIRED
ADDRESS			СІТУ		STATE ZIP
PHONE NUMBER		DIAGNO	OSIS CODE(S)		
			PROVIDER INFORMATION		
PROVIDER NAME			PHONE NUMBER		FAX NUMBER
REQUIRED			REQUIRED		REQUIRED
PROVIDER SIGNATURE			FACILITY	REQU	IRED
			COMPREHENSIVE MENTAL HEALTH		☐ YAKIMA UROLOGY
REQUIRED			GOOD SAMARITAN		☐ UNION GOSPEL MISSION
			YAKIMA PEDIATRICS		OTHER
PLEASE ATTACH OR	PRO	VID	E COMPLETE BILLING INFO	RMAT	ION ON THE NEXT PAGE
NOTE: DIAGNOSIS INFORMATION MUST BE SUBMITTED FOR E	ACH TEST	ORDER	RED. MEDICARE/MEDICAID GENERALLY DOES NOT COVE	R ROUTINE	SCREENING TESTS AND WILL ONLY PAY FOR TESTS DEEMED MEDICALLY
DATE & TIME COLLECTED		NI	ECESSARY FOR THE TREATMENT/DIAGNOSIS OF THE PA		ED GREEN VEH OW LAV DINIV DILIE CTOOL LUDING COLOR
DATE & TIME COLLECTED REQUIRED			CONTAINERS SUBMITTED ***ALL SPECIMENS MUST BE LABELED		ED GREEN YELLOW LAV. PINK BLUE STOOL URINE SWAB
/ / :			PM 2 PATIENT IDENTIFIERS***		
CHEMISTRY PANELS			CHEMISTRY (CONTINUED)		URINE TESTS
BASIC METABOLIC PANEL (NA, K, CL, CO ₂ , GLU, BUN, CRE, CA, AGAP, GFR)	CX8P	□ s	ODIUM	NA	☐ CHLAMY/GONORRHOEAE/TRICHOMONAS, PCR CHGCT
COMPREHENSIVE METABOLIC PANEL	CMP	□т	HYROID STIMULATING HORMONE	TSH	☐ CREATININE, RANDOM UCRR
(CX8P, TP, ALB, TBIL, AST, ALKP, ALT)		□ ті	HYROID STIMULATING HORMONE, REFLEX R	TSHR	☐ DRUG SCREEN, URINE DSU
L ELECTROLYTES PANEL (NA, K, CL, CO ₂)	LYTE	_	HYROXINE, FREE (T4)	FT4	☐ MICROALBUMIN UMALB
☐ HEPATIC FUNCTION PANEL	HFP		RIIODOTHYRONINE, FREE (T3)	FT3	☐ URINALYSIS, MACROSCOPIC URMAC
(ALB, TP, TBIL, AST, ALKP, ALT)	DENID	_	ROPONIN I	TROP	☐ URINE CULTURE ☐ ☐ Cath ☐ Clean Catch URNC
CX8P, ALB, PHOS)	RENP	_	IREA NITROGEN	BUN	***Culture will not be performed if high risk is marked NO***
☐ LIPID PANEL	LIPID		IRIC ACID	URIC	☐ URINALYSIS, CULTURE IF INDICATED ①②
(CHOL, TRIG, HDL, LDL)			COAGULATION & HEMATOLOG		①Is patient high risk for UTI? ☐ Yes ☐ No
CHEMISTRY		□с	OMPLETE BLOOD COUNT	CBC	IF YES, SELECT HIGH RISK INDICATIONS
L ALT	ALT	_	OAGULATION SURVEY	CS	☐ Complex urological pt ☐ GU surgery w/in 72 hours
L ALBUMIN	ALB	_ `	-DIMER	DIM	☐ Immunocompromised
L ALKALINE PHOSPHATASE (ALP)	ALKP	□ FI	IBRINOGEN	FIBRIN	☐ Pediatrics < 3 years old
☐ AMYLASE	AMY	_	EMOGLOBIN & HEMATOCRIT	HNHL	☐ Pregnant
☐ AST	AST	_	EMOGRAM (CBC W/O DIFF)	HGML	☐ Renal Transplant
B-TYPE NATRIURETIC PEPTIDE	BNP		EPARIN (ANTI-FACTOR Xa)	1UFH	②Is patient symptomatic for UTI? ☐ Yes ☐ No IF YES, SELECT UTI SYMPTOMS
☐ BILIRUBIN, DIRECT	DBIL	_	EPARIN, LOW MOLECULAR WEIGHT	LMWH	□ Ducuria / fraquancy
☐ BILIRUBIN, TOTAL	TBIL	_	LATELET COUNT	1PLT	☐ Flank pain
C-REACTIVE PROTEIN	CRP	_	ROTHROMBIN TIME (INR)	PTINR	☐ Suprapubic pain
CALCIUM, TOTAL	CA	_	ARTIAL THROMBOPLASTIN TIME (PTT)	PTT	☐ T >100.4F or < 95F, no other source ☐ Sepsis and no other source
CARBON DIOXIDE, TOTAL	CO2	_	EDIMENTATION RATE	WSR	☐ Sepsis and no other source ☐ Acute hematuria
CHOLESTEROL, TOTAL	CHOL			WSIN	☐ New/worsening incontinence
CORTISOL, RANDOM	CORT		STOOL TESTS		
CK, TOTAL	CK	_	LOSTRIDIOIDES DIFFICILE TOXIN, EIA R	CDIFF	VIROLOGY
☐ CREATININE	CRE	_	NTERIC PARASITE PANEL, PCR	EPPAN	☐ COMPREHENSIVE RESPIRATORY PANEL, PCR RSPCR
ETHANOL (ETHYL ALCOHOL)	ETOH	∐ FI	ECAL OCCULT BLOOD	FOB	☐ HEPATITIS PROFILE HEPP
FOLATE	FOL		MICROBIOLOGY		☐ HIV 1&2 ANTIBODY 🗷 HIVCOM
GAMMA GLUTAMYL TRANSFERASE (GGT)	GGT	□ A	EROBIC (WOUND) CULTURE [†]	WNDC	☐ INFLUENZA A&B, RSV, SARS-CoV-2, PCR RSPCR2
GLUCOSE	GLU		NAEROBIC CULTURE [†]	ANERC	☐ MONONUCLEOSIS MONO
☐ IRON	FET		LUID CULTURE (LARGE VOLUME) †	FLDC	□ RUBELLA (IMMUNE STATUS) RUBE
☐ LACTATE DEHYDROGENASE (LDH)	LD		ESPIRATORY CULTURE [†]	RESPC	SARS-CoV-2, PCR (COVID-19) COV19
☐ LIPASE	LIPA		HROAT STREP SCREEN	THRSS	OTHER TESTS/COMMENTS
☐ MAGNESIUM	MG		JOHLEN	55	
☐ PHOSPHORUS	PHOS				
□ POTASSIUM	K	 tsa	DURCE:		
☐ PROTEIN, TOTAL	TP	_ '30	JUNCE		R = REFLEX TESTING AUTOMATICALLY PERFORMED IF INDICATED

	BILLING INFORMAT					
		NANCE TO THE OUTREACH LAB REQUISITION. YOU MAY ATTACH THE REQUIRED INFORMATION. MISSING OR INCOMPLETE BILLING				
	MEDICARE	☐ MEDICAID				
☐ CLIENT	☐ INSURANCE	☐ PATIENT				
PRIMARY						
SUBSCRIBER NAME		SOCIAL SECURITY #				
RELATIONSHIP TO PATIENT		PHONE #				
INSURANCE COMPANY						
GROUP #		MEMBER/SUBSCRIBER #				
ADDRESS OF RESPONSIBLE PARTY		1				
PRIMARY CARE PHYSICIAN						
SUBSCRIBER NAME	SECONDARY	SOCIAL SECURITY #				
JODGCHIDER NAME		SOCIAL SECONITY #				
RELATIONSHIP TO PATIENT		PHONE #				
INSURANCE COMPANY		1				
GROUP#		MEMBER/SUBSCRIBER #				
ADDRESS OF RESPONSIBLE PARTY		1				
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.

TEST CATALOG



