



NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

Laboratory Services

Area 1: Patient Information

Print legibly patient's full last name, first name and middle initial, date of birth, address, phone number, race, ethnicity, sex.

Area 2: Parent/Guardian and Billing Information (when Billing the Patient's Insurance)

Print Guardian/Parent's last name, first name and middle initial, patient relationship, guardian contact phone number.

Print the insurance subscriber's last name, first name and middle initial, subscriber's date of birth, subscriber's sex, subscriber's social security number, subscriber's phone number, subscriber's address (if different from patient), insurance company's name, insurance policy and group number, insurance address and secondary insurance name.

Area 3: Specimen Information

Print the date and time the specimen was collected, the collector's full name, first and last, and the temperature at which the specimen was held before it was received in the lab.

Area 4: Test Menu Selection

Mark an "X" in the appropriate boxes for requested testing. Custom test(s) is an area reserved for frequently ordered tests by a physician. If a test does not appear on the list it can be hand printed in the blank area of the requisition. Do not overlap your "X" onto tests above or below your test selection.

Area 5: Diagnosis/ICD-10, Physician Signature

Print the Diagnosis/ICD-10 codes. This information is needed for registration, documentation of medical necessity and billing purposes. The physician or authorized staff must then print his/her name and then sign and date in order to confirm the order for laboratory testing.

Area 6: Barcode Specimen Labels

Use the barcode labels to attach to the patient's specimen and include the patient's full name on the label as well.

Important Information to Know:

At a fundamental level, there are specific pieces of information the laboratory needs before they can analyze a sample. Missing or incomplete information can lead to false or misleading data, misidentifying a sample, and other laboratory inefficiencies and are the major sources of pre-analytical error that affects the quality of total testing process and influence patient safety and outcomes. All of our requisition fields are mandatory fields that must be filled in clearly, completely and concisely. Missing patient information often results in a phone call to your office staff requesting the missing information which could delay treatment.

NATIONWIDE CHILDREN'S		Test Physician	
Laboratory Services 700 Children's Drive, Columbus, Ohio 43205 P: (614) 722-5477 / (800) 934-6575 F: (614) 722-5478 / (877) 722-5478 NationwideChildrens.org/Lab		123 Happy Doctor's Way Well City, OH 43225 P: (614) 555-1234 F: (614) 555-5678	
Please Mark Billing Option: Patient Bill: <input type="checkbox"/> / Client Bill: <input type="checkbox"/>			
Patient Information		Parent/Guardian / Billing Information	
Legal Last Name: _____		Guardian Legal Last Name: _____	
First Name: _____ MI: _____		Guardian First Name: _____ MI: _____	
MRN/ Patient ID: 1		Patient Relationship: _____	
DOB: _____		Guardian Contact Phone #: () _____	
Address: _____		Subscriber Legal Last Name: _____	
City, State, Zip: _____		Subscriber First Name and MI: _____	
Phone #: () _____		Subscriber DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: _____		Subscriber Social Security #: 2	
Ethnicity: _____		Subscriber Phone #: () _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Subscriber Address (if different from patient): _____	
Specimen Information		Insurance Co. Name: _____	
Collection Date: _____ Time: _____ AM _____ PM		Policy #: _____ Group #: _____	
Collected By (full name): 3		Insurance Address: _____	
Storage Temp: <input type="checkbox"/> Refrigerated <input type="checkbox"/> Room Temperature		Secondary Insurance Co. Name: _____	
CHEMISTRY PANELS: [] Check the Guide to Services for panel members [] Basic Metabolic Panel (BMP) [] Comprehensive Metabolic Panel (CMP) [] Electrolyte Panel (EPT) [] Hepatic Function Panel (HFP) [] Lipid Profile (LPP) CHEMISTRY TESTS: [] Albumin (ALB) [] Alk Phos (ALP) [] ALT (ALT) [] Amylase (AMYL) [] AST (AST) [] Bilirubin >15 Days (BL) [] Bilirubin, Nas <15 Days (NBIL) [] Bilirubin, Total (TBIL) [] BUN (BUN) [] Calcium (CA) [] Chloride (CL) [] Cholesterol (CHOL) [] CK (CK) [] CO2 (CO2) [] Creatinine (CREA) [] GGT (GGT) [] Glucose (GLUC) [] LDH (LDH) [] Lipase (LIP) [] Magnesium (MG) [] Phosphorus (PHOS) [] Potassium (K)			
CHEMISTRY TESTS (Continued): [] Sodium (NA) [] Total Protein (PT) [] Triglycerides (TRIG) [] Uric Acid (URIC) COAGULATION TESTS: [] APTT (APTT) Source: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Line [] PT/INR (PT) Source: <input type="checkbox"/> Venipuncture <input type="checkbox"/> Line HEMATOLOGY: [] Complete Blood Count (CBC) [] Complete Blood Count W Diff [] Reflex To Manual Diff (CD) [] Hematocrit (HCT) [] Hemoglobin (HGB) [] Hemoglobin Electrophoresis (HGBE) [] Mono Screen (MONOS) [] Platelet Count (PLTB) [] Retic Count (RETIC) [] Erythrocyte Sedimentation Rate (SED) ALLERGY PROFILES: [] Check the Guide to Services for profile members [] Respiratory Allergy Profile (PRALP) [] Region 5 Respiratory Profile (PRRSP) [] Toddler Allergy Profile - <3yrs (PBTODP)			
ALPHABETIC TESTS: [] ANA (ANA) Celiac Testing: [] Anti-Endomysial Ab, total IgG and IgA (EMA) [] Desamidated Gliadin Peptide Ab, IgA (DGLIAG) [] Desamidated Gliadin Peptide Ab, IgG (DGLIAG) [] Tissue Transglutaminase Ab, IgA (TTG) [] CRP (CRP) [] Epstein Barr Panel (EBVPL) [] Ferritin (FERR) [] Hemoglobin Screen, Filter Paper (HGBFPB) [] Hemoglobin A1C (HGBA1C) [] IgA (IGA) [] IgG (IGG) [] Lead, Blood (PBO) [] Lead, Filter Paper (PFP) Please use required Lead Requisition if Mono Screen (MONOS) Please use required Lead Requisition if Free T4 (Thyroxine Free) (FT4) [] TSH (TSH) [] Vitamin B12 (VB12) [] Vitamin D-25 Hydroxy (VITD) OTHER TESTS: [] Sweat Chloride (CLSW) *must be scheduled			
URINE TESTS: [] Urinalysis, UA) Source: _____ [] Urinalysis W/Reflex To Culture (UAR) Source: _____ [] Urine Culture, Source: _____ [] Urine Drugs Of Abuse, 6 panel (DOA) [] Urine, GC/Chlamydia Amplified Probe (CTGC) [] Urine, Trich, Vaginalis Amplified Probe, (TVAGP) Microbiology: [] Bacterial Culture, Site: _____ [] B. Pertussis/Pneumococcus by PCR (BPPERT) [] C. Difficile Toxin by PCR (CDIFN) [] Fungal Culture, Site: _____ [] Gastrointestinal Infection Array (GIA) [] Giardia/Cryptosporidium Ag Detection, stool (STGCR) [] Group A Strep rRNA Detection (GASDRP) [] MRSA Screen (Nasal Swab No Susceptibility) (MRSAC) [] Ova and Parasite Exam (OVAP) [] Respiratory Infection Array (FARVPP) Source: [] Nasopharyngeal (NP) [] Other: _____ [] Rotavirus Ag, stool (ROTAV) [] Stool Culture with E. Coli Shiga Toxin (STLC) [] Throat Culture (THNC) [] Throat Culture, Group A Strep Only (THSC) [] Wound Culture, Site: _____			
Diagnosis/ ICD-10 _____ Physician (Print name) 5 Physician's Signature (Required) _____ Date _____ Time _____			
PT NAME: XXXXXXXX PT NAME: XXXXXXXX 6 PT NAME: XXXXXXXX PT NAME: XXXXXXXX			