

ORDERING CLINICIAN INFORMATION All fields required

Clinician Name _____ NPI Number

Clinician Organization _____ Phone Number _____

Location Address _____ Secure Fax Number _____

City, State, ZIP _____ Please provide secure fax number to receive Patient results

PATIENT INFORMATION All fields required

Legal Name (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) / /

Mobile Number _____ Sex Male Female Undisclosed/Other

Insurance _____ Policy ID _____

ICD-10 CODE(S) Please select all diagnosis codes that apply. Note that the codes below are not exhaustive – provide additional codes and information as needed.

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| <p>Patients who have issues with conventional venous collection</p> <ul style="list-style-type: none"><input type="checkbox"/> R55 Syncope & collapse<input type="checkbox"/> F40.231 Fear of injections & transfusion <p>CBC, metabolic, hepatic & renal testing</p> <ul style="list-style-type: none"><input type="checkbox"/> E55.9 Vitamin D deficiency, unspecified<input type="checkbox"/> E78.2 Mixed hyperlipidemia<input type="checkbox"/> E78.5 Hyperlipidemia, unspecified<input type="checkbox"/> I10 Essential (primary) hypertension<input type="checkbox"/> E11.65 Type 2 diabetes mellitus with hyperglycemia<input type="checkbox"/> E11.9 Type 2 diabetes mellitus without complications<input type="checkbox"/> Z79.899 Other long term (current) drug therapy <p>HbA1c testing</p> <ul style="list-style-type: none"><input type="checkbox"/> R73.01 Impaired fasting glucose | <ul style="list-style-type: none"><input type="checkbox"/> R73.03 Prediabetes<input type="checkbox"/> Z79.899 Other long term (current) drug therapy <p>Lipid testing</p> <ul style="list-style-type: none"><input type="checkbox"/> E03.9 Hypothyroidism, unspecified<input type="checkbox"/> E11.9 Type 2 diabetes mellitus without complications<input type="checkbox"/> E78.2 Mixed hyperlipidemia<input type="checkbox"/> E78.5 Hyperlipidemia, unspecified<input type="checkbox"/> I10 Essential (primary) hypertension<input type="checkbox"/> I11.9 Hypertensive heart disease without heart failure<input type="checkbox"/> Z79.899 Other long term (current) drug therapy <p>Vitamin D testing</p> <ul style="list-style-type: none"><input type="checkbox"/> E21.0 Primary hyperparathyroidism<input type="checkbox"/> E55.9 Vitamin D deficiency, unspecified | <ul style="list-style-type: none"><input type="checkbox"/> M81.0 Age-related osteoporosis without current pathological fracture<input type="checkbox"/> N18.30 Chronic kidney disease, stage 3 unspecified<input type="checkbox"/> N18.31 Chronic kidney disease, stage 3a<input type="checkbox"/> N18.32 Chronic kidney disease, stage 3b<input type="checkbox"/> N18.4 Chronic kidney disease, stage 4 (severe)<input type="checkbox"/> Z79.899 Other long term (current) drug therapy <p>TSH testing</p> <ul style="list-style-type: none"><input type="checkbox"/> E03.9 Hypothyroidism, unspecified<input type="checkbox"/> E11.9 Type 2 diabetes mellitus without complications<input type="checkbox"/> E78.2 Mixed hyperlipidemia<input type="checkbox"/> E78.5 Hyperlipidemia, unspecified<input type="checkbox"/> I10 Essential (primary) hypertension | <p>PSA testing</p> <ul style="list-style-type: none"><input type="checkbox"/> C61 Malignant neoplasm of prostate<input type="checkbox"/> N40.0 Benign prostatic hyperplasia without lower urinary tract symptoms<input type="checkbox"/> N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms<input type="checkbox"/> R35.1 Nocturia<input type="checkbox"/> R97.20 Elevated prostate specific antigen (PSA)<input type="checkbox"/> Z12.5 Special screening examination for neoplasm of prostate <p><input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____</p> |
|---|---|---|--|

TEST MENU

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> 10001 Complete Blood Count (CBC) | <input type="checkbox"/> 10006 Hepatic Function Panel | <input type="checkbox"/> 10011 Lipid Panel | <input type="checkbox"/> 10014 Vitamin D 25-OH |
| <input type="checkbox"/> 10002 Complete Blood Count (CBC) without Diff | <input type="checkbox"/> 10007 Renal Function Panel | <input type="checkbox"/> 10012 Direct LDL Cholesterol | <input type="checkbox"/> 10015 TSH |
| <input type="checkbox"/> 10004 Comprehensive Metabolic Panel (CMP) | <input type="checkbox"/> 10008 Hemoglobin A1c | <input type="checkbox"/> 10013 Lipoprotein (a) | <input type="checkbox"/> 10016 PSA |
| <input type="checkbox"/> 10005 Basic Metabolic Panel (BMP) | | | |

ORDERING CLINICIAN (OR AUTHORIZED REPRESENTATIVE) SIGNATURE

I, the undersigned,* attest that I ordered the test for my eligible Patient and this order is appropriately documented in the Patient medical record. The test is medically necessary and reasonable to provide information to allow me to personalize treatment for my Patient's medical condition.

Ordering Clinician Signature (or Authorized Delegate) _____ Date (MM/DD/YYYY) / /

*Delegate has the authorization to sign supporting form and documents on behalf of the Ordering Clinician

CLINICIAN INSTRUCTIONS

- Fill in your Clinician information (*We cannot process the request without your NPI number*)
- Fill in your Patient's information
- Select which ICD-10 codes apply to your Patient (*If additional codes are needed, please provide in blank spaces available*)
- Select which tests you would like to order for your Patient
- Please sign and date
- Please fax your Patient's order to **+1 (512) 233-2691** (*A faxed order is required as our collection sites cannot process paper orders*)