

PT. NO.

NAME (Last, First)

D.O.B.

CLINICAL LAB REQUEST

UW MEDICINE
REFERENCE LABORATORY SERVICES

University of Washington Medical Center
1959 NE Pacific St, NW 220
Seattle WA, 98195

UW LAB ACC. #	
LOGGED IN BY:	PROCESSED BY:

General

1. Completely fill in left section. Tests in **BOLD** are available STAT.
2. Use a separate request form for each specimen type submitted.
3. For unlisted tests - see our online guide at <http://byblos.labmed.washington.edu>.
4. Reflexive tests, panels and special testing information are indicated by an *. Information is on the **back page**.

M
 F

NOTE:

When ordering tests for which Medicare reimbursement will be sought, physicians should only order tests which are medically necessary for diagnosis or treatment of the patient. You should be aware that Medicare generally does not cover routine screening tests, and will only pay for tests that are covered by the program and are reasonable and necessary to treat or diagnose the patient.

ORDERING PHYSICIAN / PHONE #		UPIN #	
REQUIRED		REQUIRED	
SPECIMEN TYPE	<input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Urine <input type="checkbox"/> CSF		
	<input type="checkbox"/> Whole Blood <input type="checkbox"/> Stool <input type="checkbox"/> Amniotic <input type="checkbox"/> Other		
DATE & TIME COLLECTED		<input type="checkbox"/> AM <input type="checkbox"/> PM	
REQUIRED			
SENDER SPECIMEN #			
TIMED URINE COLLECTION	DATES		TIMES
	START		
	FINISH		
INTERVAL (hours, min.)		TOTAL VOLUME	
ICD9 (diagnosis) code			
REQUIRED			
SEND REPORT TO (Hospital, Clinic, Physician)			
ADDRESS			
CITY		STATE	ZIP
TELEPHONE			
PATIENT ADDRESS			
CITY		STATE	ZIP
TELEPHONE		PATIENT SOC. SEC. #	
SUBSCRIBER NAME			
SUBSCRIBER ID. #			
GROUP#			
Premera Blue Cross Regence DSHS (attach current coupon)			
Medicare (answer required to question below)			
Is this either a hospital outpatient or inpatient? Yes No			
(see reverse for additional information)			
OTHER INSURANCE NAME/ADDRESS			

<input type="checkbox"/> ACID PHOSPHATASE*	ACID
<input type="checkbox"/> ACTH*	ACTH
<input type="checkbox"/> ACTIVATED PROTEIN C RESISTANCE	APCR
<input type="checkbox"/> ALBUMIN (MICRO), URINE	UMALB
<input type="checkbox"/> ALDOLASE	ALASE
<input type="checkbox"/> ALPHA-1-ANTITRYPSIN	A1AT
<input type="checkbox"/> ALPHA FETOPROTEIN	___Tumor AFPNOT
___Amniotic AAFPX	___Gest. Age
<input type="checkbox"/> ALUMINUM	AL
<input type="checkbox"/> AMMONIA*	PLNH3
<input type="checkbox"/> AMYLASE	AY with/
ANTIBODY to:	
___ Citrullinated Peptides	CCP ___ dsDNA DNAEL
___ ENA (Sm, RNP, SSA/B)	AENP ___ GBM GBM
___ H. Pylori	HPYL ___ Jo-1 AJO1
___ LKM	ALKMA ___ Mitochondrial AMITO
___ Neuronal	ANEUR ___ Neuronal, CSF CANEUR
___ Parietal Cell	APCA ___ SCL-70 SCL70
___ Sm	SMG ___ Sm/RNP SMRNP
___ Smooth Muscle	ASMA ___ SSA/Ro SSAG
___ SSB/La	SSBG
<input type="checkbox"/> ANTI-BETA-2 GLYCOPROTEIN-I	B2GP
<input type="checkbox"/> ANTI-NEUTROPHIL CYTOPLASMIC AB (ANCA)	
(If all 3 tests ordered, log ANCAG)	
___ IFA ANCAIF	___ MPO ANCAM ___ PR3 ANCAC
<input type="checkbox"/> ANTI-NUCLEAR ANTIBODIES	ANAG
___ With Reflexive Testing*	ANARP
<input type="checkbox"/> ANTI-PHOSPHOLIPID/CARDIOLIPINS*	APHOSG
<input type="checkbox"/> ANTI-THROMBIN III ACTIVITY	AT3
<input type="checkbox"/> APOLIPOPROTEIN	___A1 APOA1 ___ B APOB
<input type="checkbox"/> BENCE-JONES	___ID UIFIXG ___QUANT. UBJ
<input type="checkbox"/> BETA-2-MICROGLOBULIN	BETA2, CBETA2
<input type="checkbox"/> BILIRUBIN (OD450)*	___Gestation ___weeks ABIL
<input type="checkbox"/> BILIRUBIN, CHLORO EXTRACTION	ABILCE
<input type="checkbox"/> B TYPE NATRIURETIC PEPTIDE*	BNAP
<input type="checkbox"/> BONE ALKALINE PHOSPHATASE	BONAP
<input type="checkbox"/> C1 ESTERASE INHIBITOR (If both ordered C1EP)	
___ Functional C1EF	___ Protein Level C1EPR
___ CA 125	CA125
___ CA 27.29	CA27
<input type="checkbox"/> CALCIUM, IONIZED*	SRIC, WIC
<input type="checkbox"/> CALCIUM, URINE	UCA
<input type="checkbox"/> CAROTENE*	CAR
<input type="checkbox"/> CEA (Carcinoembryonic Antigen)	CEAG
<input type="checkbox"/> CELIAC ANTIBODIES	CELIAC
___ Anti-Endomysial	AEMYA
<input type="checkbox"/> Anti-tissue Transglutaminase	
___ IgA ATTGA	___ IgG ATTGG ___both TTG
<input type="checkbox"/> Anti-Gliadin	
___ IgA AGLIAA	___ IgG AGLIAG ___both GLIAD
<input type="checkbox"/> CERULOPLASMIN	CPLS
<input type="checkbox"/> CHOLESTEROL, DIRECT, LDL	DLDL
<input type="checkbox"/> CHROMOGENIC FACTOR X	CHRF10
<input type="checkbox"/> CITRATE, URINE	UCTRC
<input type="checkbox"/> COLD AGGLUTININ	
___ Titer CAGT	___ ID CAGIDG
<input type="checkbox"/> COMPLEMENT	___C1 C1 ___C3 C3
___C4 C4	___TOTAL TC
<input type="checkbox"/> COPPER	CU
<input type="checkbox"/> CORTISOL	CRT
<input type="checkbox"/> C-PEPTIDE	CPEP

<input type="checkbox"/> CRP, High Sensitivity	HSCRIP
<input type="checkbox"/> CK ISOS BY ELECTRO. CKELP, CKKIG	
<input type="checkbox"/> CK MB MASS	MBMASS
<input type="checkbox"/> CREATINE KINASE (CK), TOTAL	CK
<input type="checkbox"/> CRYOGLOBULINS*	
___ Quant. CRYOG	___ID CRYIDG
<input type="checkbox"/> CSF IgG INDEX (IgG/Alb. Ratio)	CINDG
<input type="checkbox"/> D-DIMER, QUANT.	DDI
<input type="checkbox"/> DHEA-SULFATE	DHEAS
<input type="checkbox"/> ERYTHROPOIETIN (EPO)	EPO
<input type="checkbox"/> ESTRADIOL	EDOL
<input type="checkbox"/> FACTOR 5 LEIDEN DNA	F5DNA
<input type="checkbox"/> FECAL FAT, QUANT.	SFAT
<input type="checkbox"/> FERRITIN	FER
<input type="checkbox"/> FETAL FIBRONECTIN*	FFNG
<input type="checkbox"/> FLUOR. POLAR. (Amniotic)	APOL
<input type="checkbox"/> FOLATE	FOLAT
<input type="checkbox"/> FOLLICLE STIM. HORMONE	FSH
<input type="checkbox"/> FREE LIGHT CHAINS	FLC
___ G6PD, Qual.	G6PD
<input type="checkbox"/> GAMMA GLUTAMYLTRANS.	GGT
<input type="checkbox"/> 5-HIAA, URINE	UHIA
<input type="checkbox"/> H. PYLORI Breath Test *(13CO2)	HPBT
<input type="checkbox"/> HAPTOGLOBIN	HPT
<input type="checkbox"/> HCG, BETA, QUANT.	
___ Pregnancy PG	___ Tumor Marker BHCG
___ HB A1c	A1C
<input type="checkbox"/> HB ELEC (w/o interpretation)	HBELEC
___ With Reflexive Testing* & Interp.	
for Hb-opathy/Thalassemia	THLRO
Specify Ethnic Origin	
<input type="checkbox"/> HB, QUANT.	___HbA2 HBA2
___ HbF HBF	___HbS HBSQH
<input type="checkbox"/> HEMOCHROMATOSIS DNA	HEMDNA
<input type="checkbox"/> HEPARIN ACTIVITY (Anti-Xa)	HEPACT
<input type="checkbox"/> HEPARIN INDUCED PLATELET AB	HIPAA
<input type="checkbox"/> HOMOCYSTEINE*	HMCY
<input type="checkbox"/> IMMUNE COMPLEXES	IMCG
<input type="checkbox"/> IMMUNOFIXATION	IFIX
<input type="checkbox"/> IMMUNOGLOBULINS	___IgG IGG
___ IgM IGM	___IgA IGA ___IgE IGE
<input type="checkbox"/> INSULIN, TOTAL	INS
<input type="checkbox"/> LACTATE*	___ Art ABLAC ___ Ven VLAC
___ LEAD	___ with / ZPPH PBGRP
<input type="checkbox"/> LIPASE	LPASE
<input type="checkbox"/> LIPID PANEL	LIPID
<input type="checkbox"/> LUPUS ANTICOAGULANT GRP*	LUPP
<input type="checkbox"/> LUPUS INHIBITOR ASSAY	LUPINH
<input type="checkbox"/> LUTEINIZING HORMONE	LH
<input type="checkbox"/> MYOGLOBIN	
___ Serum MYO	___ Urine* UMYO
<input type="checkbox"/> NITROGEN, TOTAL	STNIT/U/M/F
<input type="checkbox"/> N-TELOPEPTIDE w/ Creat	UNTPG
<input type="checkbox"/> OLIGOCLONAL BANDING*	COLIG
<input type="checkbox"/> OSMOLALITY	OSMO, UOSMO, FOSMO

<input type="checkbox"/> PARATHYROID HORMONE*	IPTH
___ with Calcium*	IPTHG
<input type="checkbox"/> PORPHOBILINOGEN, URINE	UPBG
<input type="checkbox"/> PROGESTERONE	PROG
<input type="checkbox"/> PROLACTIN	PRL
<input type="checkbox"/> PROTEIN-C ACTIVITY	PCCLOT
<input type="checkbox"/> PROTEIN ELECTRO.	CELP/ELP/UELP
___ With Reflexive Testing*	ELPP/UELPP
<input type="checkbox"/> PROTEIN-S ANTIGEN, FREE	PSAGF
<input type="checkbox"/> PROTHROMBIN DNA (G20210A)	PRODS
<input type="checkbox"/> PSA, TOTAL	
___ Monitor PSAMON	___ Screen PSASCR
<input type="checkbox"/> PSA, TOTAL & REFLEX. FREE*	PSAFRP
<input type="checkbox"/> PSA, ULTRASENSITIVE	PSAUS
<input type="checkbox"/> RETICULOCYTE COUNT	RETIC/HRETIC
<input type="checkbox"/> RHEUMATOID FACTOR	RF
<input type="checkbox"/> SEX HORMONE BINDING GLOB.	SHBG
<input type="checkbox"/> T CELL SUBSETS	TCSA
<input type="checkbox"/> TESTOSTERONE	
___ Total TEST	___ Free FTSTAD (both FTTEST)
<input type="checkbox"/> THROMBOSIS PANELS*	
___ Comprehensive Venous	CVTHR2
___ Venous	VTHR2
___ F8 + CRP	F8THR
<input type="checkbox"/> THYROGLOBULIN BATTERY*	THGLBN
<input type="checkbox"/> THYROID ANTIBODIES	
___ Anti-Thyroid Peroxidase	ATPO
___ Anti-Thyroglobulin	ATG
<input type="checkbox"/> THYROID TESTING:	
___ T3 T3	___ TSH TSH
___ T4 T4	___ T4 T4
___ T4, Free T4FR	___ T3, Free T3FR
<input type="checkbox"/> TRANSFERRIN	TRSF
<input type="checkbox"/> TRANSTHYRETIN (Pre-Albumin)	TTHY
<input type="checkbox"/> TROPONIN - I	TROPIG
<input type="checkbox"/> VISCOSITY, SERUM	SRVIS
<input type="checkbox"/> VITAMIN(s)*	___ VITB1G, VITB2G,
___ VITB6G, VITD6G	others are VIT#
<input type="checkbox"/> VWF DISEASE GROUP*	VWDG
<input type="checkbox"/> VWF COLLAGEN BINDING	VWFCB
<input type="checkbox"/> ZINC*	ZN, UZN
<input type="checkbox"/> ZINC PROTOPOR / HEME RATIO	ZPPH

Other Requests/ Comments:

HCFA MEDICAL NECESSITY INFORMATION

It is our policy to provide health care providers with the ability to order only those lab tests medically necessary for the individual patient and to ensure that the convenience of ordering standard panels and custom profiles does not impact this ability. While we recognize the value of this convenience, indiscriminate use of panels and profiles can lead to ordering tests that are not medically necessary. Therefore, all tests offered in our panels and profiles can be ordered individually as well. If a component test is not listed individually on the request form, it may be written in the "OTHER REQUESTS" box. We encourage you to order individual tests or a less inclusive profile when not all of the tests included in the panel or profile are medically necessary for the individual patient.

REFLEXIVE TESTING DESCRIPTIONS

AMYLASE WITH REFLEXIVE FRACTIONATION

If the total amylase value is above the reference range, a reflexive fractionation is performed which reports both pancreatic and salivary fractions.

ANTI-NUCLEAR ANTIBODIES WITH REFLEXIVE TESTING

Initial screening includes testing for ANA and anti-SSA. If the initial screening results are positive for ANA, additional testing for anti-dsDNA and specific antibody testing for antibodies to Sm, RNP and SSB (Extractable Nuclear Antigens - ENA) will be performed.

HEMOGLOBIN ELECTROPHORESIS -

THALASSEMIA/HEMOGLOBINOPATHY REFLEXIVE GROUP

Initial testing includes a CBC and isoelectric focusing hb electrophoresis (IEF). If CBC is microcytic (or if patient is at-risk for thalassemia with normal indices), ZPPH, ferritin, RBC inclusion bodies, and if possible, quantitative HbF and HbA2 are performed. If a variant hb is detected on IEF, citrate agar hb electrophoresis is performed and if possible, the variant hb is quantitated. An interpretive report is provided. (No interpretive report if only qualitative hb electrophoresis is ordered). Exceptions include young children for whom Hb Bart's was detected on the state lab newborn screen and patients of Greek or Italian ancestry who appear to be normal. In the former case, we perform a BCB inclusion body test to exclude a significant alpha-thalassemia trait and HB A2 quantification to exclude coincident beta thalassemia trait. In the latter case we quantify Hb A2 and perform a BCB inclusion body test if the Hb A2 is elevated to exclude combined alpha- and beta-thalassemia traits.

In cases where an unusual hemoglobin variant is detected, DNA may be isolated to allow sequencing of the alpha and beta globin genes to identify the variant hemoglobin. If you do not want this additional testing, write "I do not want DNA testing" on the front of this form under "Other Requests/Comments:" OR check the "I do not want DNA testing" box on the clinical data sheet. Include a clinical data sheet for the Thalassemia Reflexive Panel, call 206.685.6066 or use Appendix C in the Guide to Laboratory Testing.

If the hematocrit is elevated, citrate agar electrophoresis will be performed to detect a high oxygen affinity hemoglobin. (These variants generally are not detected by isoelectric focusing since the amino acid changes in these variants do not cause a net change in the charge of the proteins.)

PORPHYRIN REFLEXIVE PANEL

Testing requires 3 specimens, Blood, Urine and Stool. See the Guide to Laboratory Testing or the online test catalog for detailed information, byblos.labmed.washington.edu/bcard/search.asp

PROTEIN ELECTROPHORESIS REFLEXIVE TESTING

Initial testing is performed for serum protein electrophoresis. Samples demonstrating unusual protein band restrictions will be referred for immunofixation to identify.

PROSTATE SPECIFIC ANTIGEN REFLEXIVE PANEL

Free PSA testing will be performed when total PSA results are 2.0-15.0 ng/mL, done at an additional charge. Contact the lab medicine resident on call at (206) 598-6190 to request testing outside this range.

THYROGLOBULIN BATTERY

Initial screen includes testing for Thyroglobulin and Anti-Thyroglobulin. If the antibody is positive, Thyroglobulin Recovery testing will be added at no additional charge.

GROUP/PANELS TESTING

ANTI-PHOSPHOLIPIDS GROUP/CARDIOLIPINS - Includes Beta-2 Glycoprotein-I, Cardiolipins, A, G, M

LUPUS ANTICOAGULANT - Includes Lupus Inhibitor, Anti-Phospholipid and Cardiolipins THROMBOSIS PANELS

- Arterial - includes CRP, PAI-1, Homocysteine, Tissue Plasminogen Activator Antigen & Lupus Inhibitor
- Comprehensive Venous - includes Venous Panel and Prothrombin DNA Screen
- Venous - Includes Activated Protein C Resis. Anti-Thrombin III, Protein C Activity, Protein-S Free Antigen, and Lupus Inhibitor

VON WILLEBRAND DISEASE GROUP - Includes Von Willebrand Factor Antigen, Factor VIII Activity, Von Willebrand Factor Multimer and VWF Collagen Binding

MEDICARE BILLING INFORMATION

Medicare billing policy prevents us from submitting a Medicare claim for laboratory testing referred to us on hospital inpatients or hospital outpatients. For these samples, we will bill the sending location.

SPECIAL COLLECTION REQUIREMENTS

The information below can be found in the Guide to Laboratory Testing or on our website at <http://byblos.labmed.washington.edu/bcard/search.asp>

ACID PHOSPHATASE Specimen should be preserved in 25uL of 0.7M Acetic Acid for every mL of serum.

ACTH One 7 mL EDTA (purple top) tube, chill tube on wet ice before drawing blood, send to laboratory immediately on wet ice.

AMMONIA One 5 mL green or lime green Hemogard (SST) tube, send to laboratory immediately on wet ice.

B-TYPE NATRIURETIC PEPTIDE Collect in a plastic tube with EDTA anticoagulant. Separate plasma from cells quickly after collection. Deliver plasma to lab frozen or refrigerated.

BILIRUBIN (OD450)/Chloroform Extraction Performed on amniotic fluid. Protect from light. If hemoglobin is present in the OD450, a Chloroform Extraction is performed.

CALCIUM, IONIZED 7 mL plain red or gold vacutainer tube. Allow to clot at room temperature, centrifuge with stopper within 1.5 hours of collection. Send entire unopened tube. Sarstedt, green top and microtainers are not acceptable.

CAROTENE One 10 mL red top tube. Wrap in foil to protect sample from light.

CRYOGLOBULINS Two 10 mL red top tubes, specimen must be maintained at 37°C and transported to lab as soon as possible at 37°C.

FETAL FIBRONECTIN Call Community Services for collection kits, 206 598-6066 or 800 713-5198

H. PYLORI BREATH TEST Call Community Services at 206 598-6066 or 800 713-5198 for information on obtaining test.

HOMOCYSTEINE, TOTAL One 5 mL EDTA (purple top) tube, chill tube on wet ice before drawing blood, send to laboratory immediately on wet ice.

L-LACTATE One 5 mL gray top tube, send to laboratory immediately on wet ice.

MYOGLOBIN, URINE Myoglobin in urine is UNSTABLE (30% decrease in 30 min.). Transfer 10 mL urine to a Urine Myoglobin Preservative Tube immediately upon collection. These Myoglobin preservative tubes, which contain 200 mg of sodium bicarbonate, are available from the laboratory and should be on hand prior to collection.

OLIGOCLONAL BANDING Testing requires 2 specimens, a CSF & a serum.

PARATHYROID HORMONE 7 mL red top. Preferred: Clot 20 minutes at room temperature. Centrifuge, separate and freeze immediately. Acceptable: Serum clotted in the cold (1-2 hours); centrifuged, separated and frozen immediately.

PORPHYRINS and PORPHOBILINOGENS All tests need to be protected from light. See reflexive section for Porphyrin Reflexive Panel.

RENIN One 7 mL lavender top tube, collected at room temperature. Send to laboratory immediately.

VITAMINS A OR E One 5 mL green top tube. Wrap in foil to protect from light.

ZINC One 10 mL red or green top Sarstedt syringe. No contact with glass.