

Patient Information [Must be Complete]			PHILADELPHIA NURSING HOME		Client Code: ZZFIPNH
NAME (last, first)			2100 W. GIRARD AVE. PHILA., PA 19130		(P) 215.685.0800 (F)
ADDRESS		ROOM #	<input type="checkbox"/> ANOSIKE,VIDA <input type="checkbox"/> AZIZI,S.AUSIM <input type="checkbox"/> BURDEN,THEODORE <input type="checkbox"/> ENEANYA,DENNIS <input type="checkbox"/> GIULIANO,ROBERT <input type="checkbox"/> GRAVES,VAUGHN <input type="checkbox"/> MARTIN,KENNETH <input type="checkbox"/> MAITIN,IAN BRUCE <input type="checkbox"/> MILLER,DAVID		<input type="checkbox"/> NEWTON,GENE <input type="checkbox"/> PICCONE,MICHELE <input type="checkbox"/> RAM,NARD <input type="checkbox"/> SATTEN,NEAL <input type="checkbox"/> SAYEED,MOHAMMAD <input type="checkbox"/> VERSHOVSKY,FELIX <input type="checkbox"/> WOODRING,ALBERT <input type="checkbox"/> ZION,ROBERT
CITY :	STATE	ZIP CODE	<input type="checkbox"/> PHYSICIAN SIGNATURE _____		
SS#	SEX (circle) M F	MARITAL STATUS S M UNK			
DOB	TELEPHONE 215-685-0800				

ICD-9 DIAGNOSIS CODE(S) - MUST BE PROVIDED	COLLECTED BY:	DATE/TIME:

Primary Insurance Information		Secondary Insurance Information	
Check one <input type="checkbox"/> Medicare Part B (M01) <input type="checkbox"/> Medicaid (P01) <input type="checkbox"/> Blue Cross (B01) <input type="checkbox"/> Personal Choice (B06) <input type="checkbox"/> Americhoice (G50) <input type="checkbox"/> Keystone Mercy Hlth Plan (U15) <input type="checkbox"/> Keystone Health Plan East (K60) capitated physicians only <input type="checkbox"/> Bill:PHILADELPHIA NURSING HOME (I24) <input type="checkbox"/> Other:	Insurance Name Policy # Group # Subscriber Name (If different than pt) Relationship to insured <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> dependent	Check one <input type="checkbox"/> Medicare Part B (M01) <input type="checkbox"/> Medicaid (P01) <input type="checkbox"/> Blue Cross (B01) <input type="checkbox"/> Personal Choice (B06) <input type="checkbox"/> Blue Cross 65 (B65) <input type="checkbox"/> AARP (I11) <input type="checkbox"/> Other:	Insurance Name Policy # Group # Subscriber Name (If different than pt) Relationship to insured <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> dependent

PHYSICIAN'S LABORATORY ORDERS

LAB	PANELS	LAB	OTHER TESTS	LAB	OTHER TESTS	LAB	OTHER TESTS
<input type="checkbox"/>	4919 ACUTE HEPATITIS PANEL <small>(HA-IgM, Hbc-IgM, HbsAg, Hep-C)</small>	<input type="checkbox"/>	4818 ANTINUCLEAR AB	<input type="checkbox"/>	4862 HIV AB SCREEN** <small>**Keep consent on file</small>	<input type="checkbox"/>	3200 THEOPHYLLINE
<input type="checkbox"/>	3049 BASIC METABOLIC PANEL <small>(LYTES, BUN, CREAT, GLUC, CA)</small>	<input type="checkbox"/>	3015 AST	<input type="checkbox"/>	7271 HOMOCYSTEINE (Plasma)	<input type="checkbox"/>	3625 THYROGLOBULIN ANTIBODIES
<input type="checkbox"/>	3496 COMPREHENSIVE PANEL <small>(ALB, ALKP, TBIL, BUN, CA, CREAT, LYTES, GLUC, TP ALT, AST)</small>	<input type="checkbox"/>	3020 BILIRUBIN, DIRECT	<input type="checkbox"/>	3701 IRON/TRANSFERRIN/TIBC	<input type="checkbox"/>	7166 TRANSFERRIN
<input type="checkbox"/>	3497 ELECTROLYTES	<input type="checkbox"/>	3019 BILIRUBIN, TOTAL	<input type="checkbox"/>	7119 LEAD	<input type="checkbox"/>	3620 TSH
<input type="checkbox"/>	3040 LIPID PANEL <small>(CHOL, TRIG, HDL, LDL)</small>	<input type="checkbox"/>	3006 BUN	<input type="checkbox"/>	7122 LH	<input type="checkbox"/>	3008 URIC ACID
<input type="checkbox"/>	3592 LIVER (HEPATIC) PANEL <small>(ALB, TBIL, DBIL, ALKP, TP, ALT, AST)</small>	<input type="checkbox"/>	7032 CA-125	<input type="checkbox"/>	3028 LIPASE	<input type="checkbox"/>	1700 URINALYSIS
LAB HEMATOLOGY		<input type="checkbox"/>	3024 CALCIUM	<input type="checkbox"/>	7123 LIPOPROTEIN (a)	<input type="checkbox"/>	4895 V ZOSTER AB
<input type="checkbox"/>	1000 CBC, DIFF, & PLT COUNT	<input type="checkbox"/>	3190 CARBEMAZEPINE	<input type="checkbox"/>	3101 LITHIUM	<input type="checkbox"/>	3720 VITAMIN B12
<input type="checkbox"/>	1040 CBC & PLATELET COUNT	<input type="checkbox"/>	3870 CEA	<input type="checkbox"/>	4870 LYME AB w/ reflex confirm	MICROBIOLOGY w/reflex confirm	
<input type="checkbox"/>	1080 HEMOGLOBIN	<input type="checkbox"/>	3029 CHOLESTEROL	<input type="checkbox"/>	3026 MAGNESIUM	SOURCE/SITE:	
<input type="checkbox"/>	1100 HEMATOCRIT	<input type="checkbox"/>	3650 CORTISOL 8 AM	<input type="checkbox"/>	7272 MICROALBUMIN, Urine	<input type="checkbox"/> 4060 C DIFF (C.DIFFICILE TOXIN A&B)	
<input type="checkbox"/>	1140 PT WITH INR	<input type="checkbox"/>	3655 CORTISOL 4 PM	<input type="checkbox"/>	4805 MONO TEST	Urethral <input type="checkbox"/> Endocervical	
<input type="checkbox"/>	1160 PTT	<input type="checkbox"/>	3007 CREATININE	<input type="checkbox"/>	1760 OCCULT BLOOD, STOOL	<input type="checkbox"/>	4911 CHLAMYDIA/GC, PCR (Aptima)
<input type="checkbox"/>	1260 RETICULOCYTE	<input type="checkbox"/>	4834 C-REACTIVE PROTEIN	<input type="checkbox"/>	3160 PHENOBARBITAL	<input type="checkbox"/>	4086 CULTURE, CAMPYLOBACTER
<input type="checkbox"/>	1280 SED RATE	<input type="checkbox"/>	3979 high sensitivity CRP (Cardio)	<input type="checkbox"/>	3025 PHOSPHORUS	<input type="checkbox"/>	4017 CULTURE, GYN
CYT CYTOLOGY		<input type="checkbox"/>	3100 DIGOXIN	<input type="checkbox"/>	3856 PREALBUMIN	<input type="checkbox"/>	4019 CULTURE, STOOL
Use cytopathology requisition		<input type="checkbox"/>	7078 ESTRADIOL	<input type="checkbox"/>	7146 PROGESTERONE	<input type="checkbox"/>	4009 CULTURE, THROAT
PTH PATHOLOGY		<input type="checkbox"/>	3715 FERRITIN	<input type="checkbox"/>	7148 PROLACTIN	<input type="checkbox"/>	4004 CULTURE, URINE
Use cytopathology requisition		<input type="checkbox"/>	3725 FOLATE	<input type="checkbox"/>	3022 PROTEIN, TOTAL	<input type="checkbox"/>	4012 CULTURE, WOUND
LAB OTHER TESTS		<input type="checkbox"/>	7088 FSH	<input type="checkbox"/>	7154 PSA, SCREEN	<input type="checkbox"/>	4065 GROUP B STREP CULT
<input type="checkbox"/>	3023 ALBUMIN	<input type="checkbox"/>	3018 GGT	<input type="checkbox"/>	*Date of Last PSA _____	<input type="checkbox"/>	4024 OVA & PARASITES
<input type="checkbox"/>	3017 ALKALINE PHOSPHATASE	<input type="checkbox"/>	3005 GLUCOSE	<input type="checkbox"/>	7152 PSA, DIAGNOSTIC	ADDITIONAL TESTS	
<input type="checkbox"/>	3016 ALT	<input type="checkbox"/>	3685 HCG, QUANT (PREG TEST)	<input type="checkbox"/>	7156 PSA with FREE PSA Reflex	<input type="checkbox"/>	_____
<input type="checkbox"/>	3027 AMYLASE	<input type="checkbox"/>	7096 HEMOGLOBIN A1C	<input type="checkbox"/>	7145 PTH, INTACT	<input type="checkbox"/>	_____
		<input type="checkbox"/>	7098 HEMOGLOBIN A1C WITH FRUCTOSAMINE REFLEX	<input type="checkbox"/>	4882 RHEUMATOID FACTOR	<input type="checkbox"/>	_____
		<input type="checkbox"/>	4807 HEP A AB, IGM	<input type="checkbox"/>	4801 RPR	<input type="checkbox"/>	_____
		<input type="checkbox"/>	4810 HEP B SURFACE AB	<input type="checkbox"/>	4804 RUBELLA SCREEN	<input type="checkbox"/>	_____
		<input type="checkbox"/>	4809 HEP B SURFACE AG	<input type="checkbox"/>	3605 T4 (THYROXINE)	<input type="checkbox"/>	_____
		<input type="checkbox"/>	4856 HEP C AB	<input type="checkbox"/>	7090 T4, FREE	<input type="checkbox"/>	_____
				<input type="checkbox"/>	7089 TESTOSTERONE, TOTAL		_____

With any payor that has a medical necessity requirement, order only those tests which are medically required for the treatment and diagnosis of the patient

For Customer Service, Please call (610) 237-4742

*** LAB USE ONLY***

- ____ SST
- ____ PLAIN RED
- ____ LAV
- ____ LT BLUE

- ____ GREEN
- ____ GRAY
- ____ URINE
- ____ URINE CULTURE

- ____ CULTURE (OTHER)
- ____ DNA PROBE
- ____ OTHER
- ____ OTHER

MHL ID NUMBER