PATHOLOGY / LABORATORY
100 WOMAN'S WAY · Baton Rouge, LA 70817
TELEPHONE: 225-924-8271
FAX: 225-924-8616
ACCREDITED WITH CAP, JCAHO
CLIA#1900463036
Pathologist: Drs Robert Koscick

Woman's exceptional care, centered on you

PGL Pathology Group Of Louisiana

PATIENT DATA

NAME, LAST	FIRST	INITIAL	SEX	DOB	AGE	SOCIAL SECURITY #

MARITAL STATUS (CIRCLE ONE)	PREGNANCY STATUS	DATE COLLECTED	TIME COLLECTED	PHYSICIAN
MARRIED SINGLE WIDOWED DIVORCED	YES PP NO UNK			

BILLING AND INSURANCE INFORMATION

BILL TO: ☐ **PATIENT** (RESPONSIBLE PARTY MUST BE COMPLETED FOR OUR RECORDS) ☐ **CLIENT ACCOUNT** **CLIENT:** _____

RESPONSIBLE PARTY NAME | RELATIONSHIP | HOME PHONE:

PATIENT ADDRESS

CITY | STATE | ZIP CODE

☐ **FASTING** ☐ **FAX-RESULTS** _____
☐ **STAT** ☐ **CALL-RESULTS** _____

CODES: ***Requires Prior Authorization**

Δ-Fasting	D-Duo Swab	R-Red Top
APT-Aptima.	G-Gray Top	S-Serum
ACD-Yellow	MT- Herpes	SCT- Call Lab
BL-Blue Top	P-Purple Top	U-Urine

Insurance/Medicare/Medicaid billing, attach a legible copy of both sides of the **patient's insurance card(s).** Complete the insurance subscriber information below:
SUBSCRIBER NAME | RELATIONSHIP TO PATIENT | SOCIAL SECURITY # | DOB

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby assign to Woman's Hospital the insurance benefits herein specified. I also authorize and request payment to be made directly to Woman's Hospital for the hospital insurance benefits specified and otherwise payable to me, but not to exceed the Hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the Hospital for all charges not paid by insurance.

DATE: | INSURED:

A DIAGNOSIS CODE MUST BE SUBMITTED FOR EACH TEST

PROFILE-PANEL-SURVEYS		DIAG
☐ BMP- Basic Metabolic	R	
☐ CMP- Comprehensive Metabolic	R	
☐ ELECTROLYTES	R	
☐ GHP – General Health (CBC, CMP,TSH)	R	
☐ HELLP Panel (includes CBC)	P, B, R	
☐ HELLPCHEM (Chemistry Only)	P, B, R	
☐ LIPID (CHOL/HDL/LIPID/LDL)	ΔR	
☐ LIVER (Hepatic)	R	
NEWBORN SCREEN TESTING	CARD	
☐ NB SCREEN ☐ NBS REPEAT ☐ NBS PRETERM		
☐ OBSTETRIC PANEL (ZZPN, PNBB)	2P,2R, S	
Includes: Type&Screen, CBC, RPR, RUB-G, HepBSag, HIV		
☐ THYROID PANEL (T7, T3U, T4, TSH)	R	
☐ **THROMBO A** (Non-Pregnant) *	P,2BL,S	
☐ **THROMBO B** (Pregnant) *	P,2BL,S	

CHEMISTRY TESTING		DIAG
GLUCOSE / INSULIN TESTING		
****2HR TEST- MUST ARRIVE BEFORE 10:00 AM****		
****3HR TEST-MUST ARRIVE BEFORE 9:00 AM****		
☐ GLU / FBS	S	
☐ GLU 1HR	S	
☐*GEST- 50gms* ☐*NONGEST- 75gms*		
☐ GLU 2HR GEST -75gms	ΔS	
☐ GLU 3HR GEST- 100gms	ΔS	
☐ GLU 2HR w/INS-75gms -GTTINS	ΔS	
☐ INSULIN	S	
☐ GLYCOSYLATED HGB A1C	P	
☐ ALBUMIN	S	
☐ ALKALINE PHOS	S	
☐ ALT (SGPT) ☐ AST (SGOT)	S	
☐ AMYLASE	S	
☐ B12 / FOLATE	S	
BILIRUBIN TESTING		DIAG
☐ TOTAL ☐ DIRECT	S	
☐ TOTAL & DIRECT (NBILTD) NEWBORN <14 days		
☐ BUN	S	
☐ CALCIUM	S	
☐ CARBON DIOXIDE	S	
☐ CHLORIDE	S	
☐ CHOLESTEROL	S	
☐ CREATININE	S	
☐ CRP (C-Reactive Protein)	S	
☐ FERRITIN	S	
☐ G GLUTAMYL TRANSFERASE	S	
☐ IRON ☐ % IRON SAT	S	
☐ TIBC- Includes Iron FE	S	
☐ LDH	S	
☐ MAGNESIUM	S	
☐ PHOSPHORUS	S	
☐ POTASSIUM	S	
☐ PROTEIN, TOTAL	S	
☐ SODIUM	S	
☐ TRIGLYCERIDES	S	
☐ URIC ACID	S	

SPECIAL CHEMISTRY		DIAG
☐ AMH- ANTIMULLERIAN HORMONE	S	
☐ CORTISOL	S	
☐ DHEA-S	S	
☐ ESTRADIOL	S	
☐ FETAL FIBRONECTIN	SCT	
☐ FSH	S	
☐ HCG TITER	S	
☐ LH- LUTEINIZING HORMONE	S	
☐ HOMOCYSTEINE	S	
☐ 17 HYDROXY PROGESTERONE	2S	
☐ INHIBIN A ☐ INHIBIN B	S	
☐ PREGNANCY TEST SERUM	S	
☐ PROGESTERONE	S	
☐ PROLACTIN	S	
☐ VITAMIN D, 25-Hydroxy	S	
☐ VITAMIN D, 1,25-Dihydroxy	S	
THYROID TESTING		DIAG
☐ T4-THYROXINE ☐ T4 FREE	S	
☐ T3 ☐ T3 FREE ☐ T3 UPTAKE	S	
☐ T7 (T3 Uptake & T4)	S	
☐ TSH (TSH)	S	
☐ TESTOSTERONE	S	
☐ TESTOSTERONE Free & Total	S	
ONCOLOGY TESTING	S	DIAG
☐ CA-125 ☐ CA15-3 ☐ CA27.29 ☐ CEA		
CHEMISTRY URINE	U	DIAG
RANDOM URINE TESTS:	24U	
☐Calcium ☐Creatinine ☐Protein		
24 HOUR URINE TESTS:	24U	
REQUIRED: Height: _____ Weight: _____		
MICROBIOLOGY / MOLECULAR		DIAG
SOURCE: _____		
OB PATIENT: ☐ **YES** ☐ **PP** ☐ **NO**		
☐ BETA STREP	D	
☐ CULTURE, ROUTINE	D	
☐ CUL ANAEROBIC	D	
☐ Throat Cult/Strep	D	
☐ MRSA DNA / PCR	SCT	
☐ STD DNA-Swab (CHD /GC /Trich)	APT	
ONLY: ☐ Chlamydia ☐ GC ☐ Trichomonas		
VIROLOGY/PARASITOLOGY		DIAG
☐ GI PANEL (Bacteria/Parasite)	STOOL	
☐ RESPIRATORY PANEL	SCT	
CHROMOSOME TESTING		DIAG
*** REQUIRES PRIOR AUTHORIZATION**		
☐ CHROMOSOME ANALYSIS, BLOOD		

HEMATOLOGY / COAG		DIAG
☐ CBC (incl differential & PLT Ct)	P	
☐ HEMOGLOBIN/HEMATOCRIT	P	
☐ HEMOGLOBINOPATHY EVAL	P	
☐ HEMOGRAM (incl PLT Ct)	P	
☐ D DIMER	P	
☐ PLATELET COUNT	P	
☐ PT ☐ PTT ☐ FIBRINOGEN	BL	
REQUIRED: Anticoagulant Therapy: ☐ Yes ☐ No		
If Yes which one: _____		
☐ RETICULOCTYE COUNT	P	
☐ SICKLE CELL SCREEN	P	
URINALYSIS ☐ **CLEAN CATCH** ☐ **CATH**		DIAG
OB PATIENT: ☐ **YES** ☐ **PP** ☐ **NO**		
PT ALLERGIC TO PENICILLIN: ☐ **YES** ☐ **NO**		
☐ URINALYSIS- Chem & Auto Micro	U	
☐ URINALYSIS, **C&S IF INDICATED**	U	
(12 yrs or older only)		
☐ URINALYSIS **AND** CULTURE	U	
☐ URINE CULTURE **ONLY**	U	
☐ HCG, Urine Qualitative (UPT)	U	
☐ STD DNA-Urine (CHD /GC /Trich)	U	
ONLY: ☐ Chlamydia ☐ GC ☐ Trichomonas		
BLOOD BANK		DIAG
☐ ABO / Rh	P,R	
☐ ANTEPARTUM RhIG	P,R	
EDC/LMP :_____		
☐ ANTIBODY TITER	P,R	
ANTIBODY _____		
☐ Type and Screen	P,R	
SEROLOGY		DIAG
☐ ANA PROFILE WITH ANA	S	
HEPATITIS / HIV TESTING	2S	
☐ A PANEL ☐ B PANEL ☐ C PANEL		
HEP B Surface ☐ AB ☐ AG		
HIV (HIV-1 & HIV-2) ANTIBODIES/AG	S	
☐ HSV ½ DNA	MT	
☐ HERPES PCR	MT or P	
*SOURCE :_____		
☐ RUBELLA IgG	S	
☐ SYPHILLIS SCREEN	S	
OTHER LABORATORY TESTS		DIAG

PHYSICIAN'S SIGNATURE _____ *(NO STAMPS)* **DATE:** _____