OmniHealth Diagnostics
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Phone 972-887-3444 | Fax 972-887-3443
CLIA# 45D2089485 | Lab Director: David Mehr, MD
www.OmniHealthDX.com

CLINICAL TESTING

PATIENT - PLEASE PRINT LEGIBLY — REQUIRED

First Name | **Last Name**

Date of Birth | **Sex** ☐ Male ☐ Female

Street Address | **Apt/Suite #**

City | **State** | **Postal Code**

ORDERING PHYSICIAN — REQUIRED

Office/Practice/Institution Name

Physician Name(s)

Street Address | **Apt/Suite #**

City | **State** | **Postal Code**

SPECIMEN INFORMATION — REQUIRED

Specimen Type | **Date of Collection** | **Time of Collection** : ☐ AM ☐ PM | **Collectors Initials**

Diagnosis (ICD-10) Codes

PATIENT INSURANCE — REQUIRED: ATTACH PATIENTS FACESHEET & COPY OF INSURANCE CARD

☐ **Private** ☐ **Self Pay** ☐ **Workers Comp** ☐ **Medicare** ☐ **Medicaid**

Insurance Company | **Policy Number**

TEST REQUESTED — REQUIRED: SELECT ALL THAT APPLY

COMMON PANELS

- ☐ **Anemia Panel** (SST; 83540; 82746; 82728; 83550; 82607)
- ☐ **Basic Metabolic Panel** (SST; 80048)
- ☐ **Complete Metabolic Panel** (SST; 80053)
- ☐ **Hepatic Function Panel** (SST; 80076)
- ☐ **Iron Panel** (SST; 83540; 83550)
- ☐ **Lipid Panel** (SST; 80061)
- ☐ **Renal Function Panel** (SST; 80069)
- ☐ **Thyroid Panel** (SST; 84481; 84480; 84439; 84436; 84443)

HEMATOLOGY

- ☐ **CBC w/Diff** (LAV; 85025)
- ☐ **CBC w/Diff & Reticulocytes** (LAV; 85025)
- ☐ **ESR - Erythrocyte Sedimentation Rate** (LAV; 85652)
- ☐ **Reticulocytes** (LAV; 85045)

COAGULATION

- ☐ **PT w/INR** (Blue; 85610)
- ☐ **PTT** (Blue; 85730)

URINALYSIS

- ☐ **Urinalysis** (Urine; 81003)
- ☐ **Urinalysis w/ Microscopic** (Urine; 81015)

CHEMISTRY

- ☐ **Albumin** (SST; 82040)
- ☐ **ALP** (SST; 84075)
- ☐ **ALT** (SST; 84460)
- ☐ **AST** (SST; 84450)
- ☐ **Bilirubin, Direct** (SST; 82248)
- ☐ **Bilirubin, Total** (SST; 82247)
- ☐ **BUN** (SST; 84520)
- ☐ **Calcium** (SST; 82310)
- ☐ **Chloride** (SST; 82435)
- ☐ **Cholesterol** (SST; 82465)
- ☐ **CO2** (SST; 82374)
- ☐ **Creatine Kinase** (SST; 82550)
- ☐ **Creatinine** (SST; 82565)
- ☐ **CRP-HS** (SST; 86141)
- ☐ **GGT** (SST; 82977)
- ☐ **Glucose** (SST; 82947)
- ☐ **HDL Cholesterol** (SST; 83718)
- ☐ **Hemoglobin A1C** (LAV; 83036)
- ☐ **Iron** (SST; 83540)
- ☐ **LDH** (SST; 83615)
- ☐ **LDL Cholesterol** (SST; 83721)
- ☐ **Lipase** (SST; 83690)
- ☐ **Magnesium** (SST; 83735)
- ☐ **Phosphorus** (SST; 84100)
- ☐ **Potassium** (SST; 84132)
- ☐ **Rheumatoid Factor** (SST; 86431)
- ☐ **Sodium** (SST; 84295)
- ☐ **TIBC** (SST; 83550)
- ☐ **Total Protein** (SST; 84155)
- ☐ **Transferrin** (SST; 84466)
- ☐ **Triglyceride** (SST; 84478)
- ☐ **UIBC** (SST; 83550)
- ☐ **Uric Acid** (SST; 84550)
- ☐ **Urine Microalbumin** (Urine; 82043)

IMMUNOASSAY

- ☐ **Anti-HBc IgM** (SST; 86705)
- ☐ **Anti-HBs** (SST; 86706)
- ☐ **Anti-HCV** (SST; 86803)
- ☐ **B-hCG** (SST; 84703)
- ☐ **CA 125 II** (SST; 86304)
- ☐ **CEA** (SST; 82378)
- ☐ **Cortisol** (SST; 82533)
- ☐ **DHEA-S** (SST; 82627)
- ☐ **Estradiol** (SST; 82670)
- ☐ **Ferritin** (SST; 82728)
- ☐ **Folate** (SST; 82746)
- ☐ **Free T3** (SST; 84481)
- ☐ **Free T4** (SST; 84439)
- ☐ **Free Testosterone** (SST; 84402)
- ☐ **FSH** (SST; 83001)
- ☐ **HAVAb IgM** (SST; 86709)
- ☐ **HBsAg Qual** (SST; 87340)
- ☐ **HIV Ag/Ab** (SST; 86703)
- ☐ **Insulin** (SST; 83525)
- ☐ **LH** (SST; 83002)
- ☐ **Progesterone** (SST; 84144)
- ☐ **Prolactin** (SST; 84146)
- ☐ **PSA, Free** (SST; 84154)
- ☐ **PSA, Total** (SST; 84153)
- ☐ **PTH, Intact** (SST; 83970)
- ☐ **SHBG** (SST; 84270)
- ☐ **Syphilis** (SST; 86780)
- ☐ **T3 Uptake** (SST; 84479)
- ☐ **T3 Total** (SST; 84480)
- ☐ **T4 Total** (SST; 84436)
- ☐ **Testosterone** (SST; 84403)
- ☐ **TSH** (SST; 84443)
- ☐ **Vitamin B12** (SST; 82607)
- ☐ **Vitamin D 25-OH** (SST; 82306)

PHYSICIAN CONSENT & MEDICAL NECESSITY FOR TESTING — REQUIRED

I authorize **OmniHealth Diagnostics** and its affiliated labs to perform testing as directed by this test requisition form. I understand and hereby acknowledge that: When ordering tests for which Medicare or Medicaid reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis of the patient. Components may be billed separately per carrier policy. NOTE: The Office of Inspector General (OIG) takes the position that a physician who orders medically unnecessary test(s) for which Medicare reimbursement is claimed, may be subject to civil penalties.

Physician Signature:_____ **Date:** _____

PATIENT ACKNOWLEDGEMENT & CONSENT — REQUIRED

I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen is accurate. I further authorize the laboratory to release the result of this testing to the ordering facility and/or my insurance company. I authorize my insurance company to pay in mail directly to **OmniHealth Diagnostics** and it's affiliated laboratories all benefits for payment of services rendered. I also authorize **OmniHealth Diagnostics** and it's affiliated laboratories to endorse any checks received on my behalf for payments of services provided. I hereby irrevocably assign to **OmniHealth Diagnostics** and it's affiliated laboratories all benefits under any policy of insurance indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action including legal suit, if for any reason my insurance company fails to make payment. This assignment also includes all rights to recover attorney fees and costs for such actions brought by the provider as my assignee.

Patient Signature: _____ **Date:** _____