

Patient Name _____ DOB _____ 502750	Patient Name _____ DOB _____ 502750	Patient Name _____ DOB _____ 502750	Patient Name _____ DOB _____ 502750
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 Lab Director: Amadeo Pesce, Ph.D.
 Lab Director: Robert Lajvardi, MD
 CLIA #05D0567262



Customer Information

REQUISITION FOR BLOOD WELLNESS TESTING

Last Name: _____ DOB: ____/____/____
 (Must be 18 years or older)

First Name: _____ Biological Sex: M F

Date Collected: ____/____/____ Attach patient demographics with insurance card

Time Collected: ____:____ AM / PM Uninsured Patient

Ordering Provider: _____

Fasting: Yes No

Ethnicity:
 White Black/African-American Hispanic/Latino/Spanish Origin Asian American Indian/Alaskan Native
 Native Hawaiian/Other Pacific Islander Other: _____ Refused

Diagnosis Code(s): _____

MALE / FEMALE WELLNESS PANEL*
<input type="checkbox"/> CBC (w/ differential), CMP, Lipid Panel, HbA1c, Insulin, B12, Ferritin, Folate, Iron, T3 Total, T4 Free, TSH (3rd Gen), Cortisol, hsCRP, DHEA-S, Estradiol (sensitive), FSH, LH, Magnesium, Phosphorus, Progesterone, Prolactin, SHBG, Testosterone Free**/Total, Uric Acid, Vitamin D 25-OH
GEL(x2) + LAV
<i>If testing a male patient, PSA Total will be performed</i>

ORGAN OR DISEASE PANEL
<input type="checkbox"/> CBC 85027 LAV
<input type="checkbox"/> CBC (w/ differential) 85025 LAV
<input type="checkbox"/> Basic Metabolic Panel* 80048 GEL
<input type="checkbox"/> Comp. Metabolic Panel* 80053 GEL
<input type="checkbox"/> Electrolyte Panel* 80051 GEL
<input type="checkbox"/> Lipid Panel* 80061 GEL
<input type="checkbox"/> Liver Function Panel* 80010 GEL
<input type="checkbox"/> Renal Function Panel* 80069 GEL
DIABETES
<input type="checkbox"/> Glucose 82947 GEL
<input type="checkbox"/> HbA1c 83036 LAV
<input type="checkbox"/> Insulin 83525 GEL
ANEMIA
<input type="checkbox"/> B12 82607 GEL
<input type="checkbox"/> Ferritin 82728 GEL
<input type="checkbox"/> Folate 82746 GEL
<input type="checkbox"/> Iron 83540 GEL
THYROID
<input type="checkbox"/> T3 Free 84481 GEL
<input type="checkbox"/> T3 Total 84481 GEL
<input type="checkbox"/> T4 Free 84436 GEL
<input type="checkbox"/> T4 Total 84436 GEL
<input type="checkbox"/> TPO Ab 86376 GEL
<input type="checkbox"/> TSH (3rd Gen) 84443 GEL

ALPHABETICAL TESTS
<input type="checkbox"/> Albumin 82040 GEL
<input type="checkbox"/> ALP 84075 GEL
<input type="checkbox"/> ALT 84460 GEL
<input type="checkbox"/> Amylase 82150 GEL
<input type="checkbox"/> Apolipoprotein A1 82172 GEL
<input type="checkbox"/> Apolipoprotein B 82172 GEL
<input type="checkbox"/> AST 84450 GEL
<input type="checkbox"/> Bilirubin, Total 82247 GEL
<input type="checkbox"/> BUN 84520 GEL
<input type="checkbox"/> Calcium 82310 GEL
<input type="checkbox"/> Carbon Dioxide 82374 GEL
<input type="checkbox"/> Chloride 82435 GEL
<input type="checkbox"/> Cholesterol 82465 GEL
<input type="checkbox"/> Cortisol 82533 GEL
<input type="checkbox"/> Creatine Kinase (CK) 82550 GEL
<input type="checkbox"/> Creatinine 82565 GEL
<input type="checkbox"/> hsCRP 86141 GEL
<input type="checkbox"/> DHEA-S 82626 GEL
<input type="checkbox"/> Estradiol (sensitive) 82670 GEL
<input type="checkbox"/> FSH 83001 GEL
<input type="checkbox"/> GGT 82977 GEL
<input type="checkbox"/> HDL Cholesterol 83718 GEL
<input type="checkbox"/> Homocysteine 83090 GEL
<input type="checkbox"/> LH 83002 GEL

ALPHABETICAL TESTS (continued)
<input type="checkbox"/> Lipase 83690 GEL
<input type="checkbox"/> Lipoprotein (a) 83695 GEL
<input type="checkbox"/> Lp-PLA2 83698 GEL
<input type="checkbox"/> Magnesium 83735 GEL
<input type="checkbox"/> Phosphorus 84100 GEL
<input type="checkbox"/> Potassium 84132 GEL
<input type="checkbox"/> Progesterone 84144 GEL
<input type="checkbox"/> Prolactin 84146 GEL
<input type="checkbox"/> PSA Total (males only) 84153 GEL
<input type="checkbox"/> SHBG 84270 GEL
<input type="checkbox"/> Sodium 84295 GEL
<input type="checkbox"/> Testosterone Free** 84402 GEL
<input type="checkbox"/> Testosterone Total 84403 GEL
<input type="checkbox"/> Total Protein 84155 GEL
<input type="checkbox"/> Triglycerides 84478 GEL
<input type="checkbox"/> Uric Acid 84550 GEL
<input type="checkbox"/> Vitamin D 25-OH 82306 GEL
<input type="checkbox"/> USE CUSTOM PROFILE

* See reverse for included tests ** Calculated test; ordering this test constitutes an order for Testosterone Total, SHBG, and Albumin

AUTHORIZATION/SIGNATURES

DONOR: I certify that the specimen and information provided is my own and has not been substituted or adulterated. I further grant permission for the testing of my specimen for the presence of drugs and/or alcohol. I authorize Birdrock Laboratories to share the information on this form and my test results with my designated insurance carrier if necessary for reimbursement, to appeal any reimbursement denial, and authorize all reimbursements to be paid directly to the laboratory in consideration of services performed. I acknowledge that Birdrock Laboratories may be outside my network of insurance and I may be responsible for the amount due as determined by said insurance. I authorize Birdrock Laboratories to release the results of this testing to the treating authorized healthcare provider or facility.

ORDERING PROVIDER: Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. I certify that the above ordered tests are medically necessary for the diagnosis and treatment of this patient. I have documented this test in the patient's chart. I acknowledge that Medicare does not generally cover routine screening tests.

Donor Authorization Signature: _____	Date: _____	Authorized Health Care Provider Signature (Required): _____	Date: _____
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