

Medtronic Sofamor Danek
 Mickey Brown
 1800 Pyramid Place
 Memphis TN 38132
 901-399-2694 MSS

Significant Clinical Information

_____ Fasting

_____ Non-Fasting



**CUSTOMIZED
 REQUEST**

(EMBOSSING AREA)

Account No. 41123775-4

Submit Separate Specimens (Not Request Forms) for each Frozen Test Requested.

Specimen Date Mo Day Yr		Specimen Time Hr Min		Patient Name (Last)		(First, MI)		Sex	Date of Birth Mo Day Yr		Age Yrs Mos		
51 6632 5786 9				Patient I.D. #		Physician I.D.		Patient/Resp. Party's Phone #					
Responsible Party or Insured's Name (Last, First)								Patient's SS #					
Address						City		State		Zip Code			
Patient's Signature				Date									
Resp. Party's Employer				Medicaid Number/HMO #				Medicare #					
Physician Name				UPIN #		Physician's Signature			Provider #				
Diagnosis Code (ICD-9)			Insurance Code or Company Name and Address					Insurance I.D. #		Workers Comp. Yes No			
Group # or Name			Relationship to Insured (Circle One) 1-Self 2-Spouse 3-Other		Urine Total 24hr. Vol. _____			Patient's Ht. _____ Wt. _____					

@ [] **138755** Donor Screening Panel 22

MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)
 Use a separate ABN when ordering tests which require an ABN. Refer to the back of this form for more information.

- @ = Subject to Medicare medical necessity guidelines
- % = Subject to Medicare frequency guidelines
- # = Medicare deems investigational

INDIVIDUAL COMPONENTS OF TEST COMBINATIONS / PROFILES LISTED IN THE SECTION ABOVE CAN BE ORDERED ABOVE.

TRAVEL LOG ID		
PST HR#	DATE	LOG#

STAT	VENIPUNCTURE	NON LABCORP	VERBAL ORDER	CHART ORDER	HANDWRITTEN	24 HR TUV	PST/PBC #
<input type="checkbox"/> 996074	<input type="checkbox"/> 996065	<input type="checkbox"/> 996239	<input type="checkbox"/> 996250	<input type="checkbox"/> 996261	<input type="checkbox"/> 996272	<input type="checkbox"/> 996283	

CHECK ONE
 03 [] ACCOUNT BILL

Apply Labels to Patient Specimens Only
 Patient Control No.

51 6632 5786 9

51 6632 5786 9

51 6632 5786 9

51 6632 5786 9

51 6632 5786 9

+

51 6632 5786 9

51 6632 5786 9

GEL SPUN	USST UNSPUN	SERUM SERUM TRNSPT	FRZ FRZ TRNS	RED RED	LAV LAVENDER	SLD SLIDE	BLU LT. BLUE	GRY GREY	GRN GREEN	RYB RYL BLU	YEL ACID	PLS PLASMA	URN URINE	24U 24 HR URINE	TA-U TART. ACID	FL FLUID	OT OTHER	BACT BACT TRNSPT	O & P KIT	PROBE PROBE TRNSPT	UN/CUL UN/CUL TRNSPT	STERL STERL TRNSPT	PECAL PECAL TRNSPT	VIRAL VIRAL TRNSPT
----------	-------------	--------------------	--------------	---------	--------------	-----------	--------------	----------	-----------	-------------	----------	------------	-----------	-----------------	-----------------	----------	----------	------------------	-----------	--------------------	----------------------	--------------------	--------------------	--------------------

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. COMPONENTS OF THE ORGAN OR DISEASE PANELS AND COMMON TEST COMBINATIONS ARE SHOWN ON THE REVERSE SIDE, AND ANY COMPONENT MAY BE ORDERED INDIVIDUALLY. COMPONENTS MAY BE BILLED SEPARATELY PER CARRIER POLICY. THE INDIVIDUAL COMPONENTS OF ANY CUSTOMIZED PROFILES HAVE BEEN DISCLOSED TO YOU AND THEY MAY ALSO BE ORDERED INDIVIDUALLY.