



**WILLIS-KNIGHTON
COMMUNITY REFERENCE LAB**

Willis-Knighton Community Reference Laboratory
2600 Greenwood Road, Shreveport, LA 71103
Client Services 318-212-4400

Medicare Secondary Payer (MSP)

Read the following questions and circle the correct responses.

Is the patient or patient's spouse currently employed? Yes No
If NO, retirement date of Patient _____ Spouse _____
Is the patient being treated for ESRD? Yes No
Is patient being treated for Black Lung Disease? Yes No
Was the injury due to a non work-related accident? Yes No
Was the illness/injury due to a work-related accident/condition? Yes No
Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? Yes No

Bill To: CLIENT PATIENT INSURANCE

Insurance Company _____

Policy/Group # _____

Secondary Insurance _____

Policy/Group # _____

Patient Information

Name _____
Last _____ First _____ MI _____
SS# _____ DOB _____ Sex _____
Race _____ Phone (_____) _____
Address _____
City _____ State _____ Zip _____

Physician Information

Physician _____
Address _____
Phone # _____
Home Health Agency _____
Fax results to _____
ICD 10 Codes _____

STAT Routine Fasting Non-fasting

Collection Date _____ **Time** _____

Microbiology Source: _____

<input type="checkbox"/> Comp Metabolic Panel (Alb,ALP,ALT,AST,TBil,BUN,Ca,Cl,CO2,Crea,Glu,K,Na,TP)	<input type="checkbox"/> Giardia/Cryptosporidium Antigen
<input type="checkbox"/> Basic Metabolic Panel (BUN,Ca,Cl,CO2,Crea,Glu,K,Na)	<input type="checkbox"/> Blood Culture
<input type="checkbox"/> Hepatic Function Panel (Alb,ALP,ALT,AST, T&DBil,TP)	<input type="checkbox"/> Chlamydia/GC
<input type="checkbox"/> Lipid Panel (Chol, HDL, Trig, LDL calc)	<input type="checkbox"/> C. Difficile
<input type="checkbox"/> Renal Function Panel (Alb,BUN,Ca,Cl,CO2,Crea,Glu,K,Na,Phos)	<input type="checkbox"/> Fungal Mount/Cult
<input type="checkbox"/> Acute Hepatitis Panel (HBsAg, HBcAb IgM, HAAb IgM,HCAb)	<input type="checkbox"/> General C&S

24 Hour Urine:

<input type="checkbox"/> 5HIAA	<input type="checkbox"/> Patient's HT: _____ WT: _____
<input type="checkbox"/> Catecholamine Fract.	<input type="checkbox"/> Metanephhrines Fract.
<input type="checkbox"/> Creatinine	<input type="checkbox"/> Protein
<input type="checkbox"/> Creatinine Clearance	<input type="checkbox"/> Sodium

<input type="checkbox"/> Creatinine Clearance	<input type="checkbox"/> Urea Clearance
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Individual Tests

<input type="checkbox"/> AFP Tumor Marker	<input type="checkbox"/> CBC no diff	<input type="checkbox"/> GGT	<input type="checkbox"/> Potassium	<input type="checkbox"/> T4 Free
<input type="checkbox"/> ALP	<input type="checkbox"/> CBC w/ diff	<input type="checkbox"/> Glucose	<input type="checkbox"/> PSA Diagnostic	<input type="checkbox"/> TIBC (includes iron)
<input type="checkbox"/> ALT	<input type="checkbox"/> CEA	<input type="checkbox"/> HgbA1C	<input type="checkbox"/> PSA Screen	<input type="checkbox"/> Troponin
<input type="checkbox"/> Ammonia	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> HCG Qual.	<input type="checkbox"/> PTH intact	<input type="checkbox"/> TSH
<input type="checkbox"/> Amylase	<input type="checkbox"/> CKMB	<input type="checkbox"/> HCG Quant.	<input type="checkbox"/> PT/INR	<input type="checkbox"/> UA Screen (dip only)
<input type="checkbox"/> ANA	<input type="checkbox"/> Creatinine	<input type="checkbox"/> Hgb/Hct	<input type="checkbox"/> PTT	<input type="checkbox"/> UA w/ micro if indicated
<input type="checkbox"/> AST	<input type="checkbox"/> CRP	<input type="checkbox"/> HIV 1&2 Screen	<input type="checkbox"/> Reticulocyte	<input type="checkbox"/> UA w/micro w/ reflex URC
<input type="checkbox"/> B12	<input type="checkbox"/> D-Dimer	<input type="checkbox"/> Iron	<input type="checkbox"/> Rheumatoid Factor	<input type="checkbox"/> UPT (HCG Qual.)
<input type="checkbox"/> BNP	<input type="checkbox"/> Digoxin	<input type="checkbox"/> LH	<input type="checkbox"/> RPR	<input type="checkbox"/> Uric Acid
<input type="checkbox"/> BUN	<input type="checkbox"/> Drug Screen	<input type="checkbox"/> Lipase	<input type="checkbox"/> Sed Rate (ESR)	<input type="checkbox"/> Urine Creatinine, random
<input type="checkbox"/> CCA 19-9	<input type="checkbox"/> Ferritin	<input type="checkbox"/> Magnesium	<input type="checkbox"/> SIEP (IEPS)	<input type="checkbox"/> Urine Protein, random
<input type="checkbox"/> CCA 125	<input type="checkbox"/> Folate	<input type="checkbox"/> Mono	<input type="checkbox"/> T3 Free	<input type="checkbox"/> Vitamin D, 25 hydroxy
<input type="checkbox"/> Calcium	<input type="checkbox"/> FSH	<input type="checkbox"/> Phosphorus	<input type="checkbox"/> T4	

Extra Tests or comments: _____

***Physician's Signature** _____

Date _____

For Office Use Only: RED SST GREEN (DARK) GREEN (LIGHT) PURPLE LIGHT BLUE GOLD

YELLOW (ACD) ROYAL BLUE PINK MICRO PURPLE MICRO GREEN MICRO RED OTHER: _____

URINE (GREY) URINE CUP 24HR URINE STOOL BODY FLUID M4 SWAB: TYPE _____