OMEGA
DIAGNOSTICS LLC

(318) 681-4354
(318) 681-6927 (fax)
1-888-318-6539

PATIENT INFORMATION

Please PRINT. A complete form is REQUIRED. PRIORITY: ☐ ROUTINE ☐ STAT ☐ FAX RESULTS ( ) ____

Patient Last Name	First	MI	Social Security Number	☐ MALE ☐ FEMALE	Date of Birth (mm/dd/yr)

Patient's Phone (Dr. needs phone # for critical value) ( )	Collection Date	Time ☐ am ☐ pm	Collected by	Physician Last Name, First, MI

Chartable comment (e.g. location, ID #)	Form completed by:

BILLING INFORMATION

BILL TO: ☐ CLIENT ACCOUNT ☐ PATIENT ☐ MEDICARE ☐ PRIMARY ☐ SECONDARY ☐ MEDICAID ☐ PRIMARY ☐ SECONDARY ☐ OTHER INSURANCE ____

Complete Section Below or ATTACH Copy of Card

The following information is REQUIRED for Medicare, Medicaid, Patient or third party billing. Without ICD-9 code AND complete insurance information, client will be billed

Medicare # LETTER	Medicaid #	OTHER INSURANCE	Insurance Company Name & Address		
Insured/Responsible Party Last Name	First Name	MI	City	State	Zip
Address			Group #	Policy #	
City/State/Zip code			Employer of Insured		

For Medicare and other insured patients: I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other government agency or insurance carrier responsible for payment any information needed for this or related Medicare or other claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment by signature.

Signature of patient or insured required!!

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When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

DIAGNOSIS/ ICD-9 CODE: ____

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PANELS
-----------------------------------------
[] ACUTE HEPATITIS PANEL          ____
[] BASIC METABOLIC PANEL          ____
[] CBC W/AUTO DIFF(RFX MANUAL)    ____
[] CBC W/MANUAL DIFF              ____
[] COMP METABOLIC PANEL (CMP)     ____
[] LIPID PROFILE                  ____
[] LIVER (HEPATIC) PROFILE        ____
[] RENAL FUNCTION PANEL           ____
=========================================
[] AMYLASE                        ____
[] BILIRUBIN DIRECT               ____
[] BILIRUBIN TOTAL                ____
[] DIGOXIN                        ____
[] DILANTIN(PHENYTOIN)            ____

[] HBS ANTIBODY                   ____
[] HBS ANTIGEN                    ____
[] HEMOGLOBIN A1C                 ____
[] HEMOGLOBIN & HEMATOCRIT        ____
[] HIV ANTIBODY                   ____
[] POTASSIUM (K+)                 ____
[] PREALBUMIN                     ____
[] PSA, DIAGNOSTIC                ____
[] PSA, SCREENING                 ____
[] PT W/INR                       ____
[] PTT                            ____
[] SEDIMENTATION RATE (ESR)       ____
[] TRIGLYCERIDES                  ____
[] TSH (THYROID STIM HORMONE)     ____
[] T4 FREE                        ____

[] UA ROUTINE(RFX MICROSCOPIC)    ____
[] UA WITH MICROSCOPIC            ____
[] UA WITHOUT MICROSCOPIC         ____
[] UA W/REFLEX CULTURE            ____
CATH(I&O)___CATH(INDW)___MID___VOID___
------------MICROBIOLOGY TESTS---------
[] CT/NG BY PCR                   ____
[] ROUTINE CULTURE                ____
SOURCE REQUIRED: ____
[] URINE CULTURE                  ____
CATH(I&O)___CATH(INDW)___MID___VOID___
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ADDITIONAL TESTS

____

Temperature of Specimen Received

☐ Acceptable ☐ Unacceptable

Follow up Y N

FOR LABORATORY USE ONLY

Triage ☐ Time ☐

____ Pink ____ Red ____ Swab ____ Fluid ____ Urine 24 hr ____ Aptima
____ SST ____ Green ____ Purple ____ Lt Blue ____ Trans Tube
____ Stool ____ PST ____ M4/UTM ____ Urine random ____ Urine Gray

Other: ____

COE ☐ Audit ☐ Bill ☐ Initials ____

44715

FORWARD TOP COPY TO LAB