



UNIVERSITY OF CONNECTICUT HEALTH CENTER  
 LABORATORY MEDICINE REQUISITION HCH-499J  
 263 Farmington Avenue, Farmington, CT 06032-2230  
 Licenses CT HP0213 CLIA 070D0092519  
 Tel: (860) 679-2498 • Fax: (860) 679-1401

PATIENT NAME \_\_\_\_\_  
 MRN (T00#) \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_  
 CLINIC LOCATION \_\_\_\_\_

REQUISITION DATE \_\_\_\_\_  
 Requesting Physician (please print) \_\_\_\_\_  
 Requesting Physician Signature: \_\_\_\_\_

ADDITIONAL REPORTS TO CLINICS OR OUTSIDE PHYSICIANS: \_\_\_\_\_

PCP (please print) \_\_\_\_\_

OTHER: \_\_\_\_\_

ATTENDING:

TEL#: \_\_\_\_\_ FAX#: \_\_\_\_\_

Appell (4316) <input type="checkbox"/>	Carley (6987) <input type="checkbox"/>	Hiser (13457) <input type="checkbox"/>	Moss (2514) <input type="checkbox"/>
Ave'Lallemant (8916) <input type="checkbox"/>	Fischer (1120) <input type="checkbox"/>	Lakshminarayanan (6516) <input type="checkbox"/>	Rockland (3021) <input type="checkbox"/>
Berkowitz (6454) <input type="checkbox"/>	Garibaldi (8489) <input type="checkbox"/>	Levinbook (8953) <input type="checkbox"/>	Samson (14824) <input type="checkbox"/>

LOCATION - CIRCLE ONE: WHOIM EHOIM

ORDER COMMENT: Patient Phone #: \_\_\_\_\_

Insurance Carrier

Medicare A&B <input type="checkbox"/>	Aetna US Hlthcare <input type="checkbox"/>	Connecticare <input type="checkbox"/>
Medicare, Other <input type="checkbox"/>	BC/BS <input type="checkbox"/>	Healthnet <input type="checkbox"/>
Medicaid <input type="checkbox"/>	Cigna <input type="checkbox"/>	Other <input type="checkbox"/>

Diagnosis supporting Medical Necessity for EACH test ordered.

Please check:  
 Is patient on long term meds? (V58.69)  
 Is patient on coumadin? (V58.61)

COLLECTED BY: \_\_\_\_\_ Collection Date/Time: \_\_\_\_\_  
 URINE COLLECTION VOL: \_\_\_\_\_ ml 24 hrs Random Hrs.  Routine  STAT 5/06

DX \_\_\_\_\_ DX \_\_\_\_\_ DX \_\_\_\_\_ DX \_\_\_\_\_

BASIC METABOLIC

NA	Sodium	
K	Potassium	
CL	Chloride	
CO2	CO2	
GLU	Glucose	
BUN	BUN	
CREAT	Creatinine	
CA	Calcium	

LIPID

CHOL	Cholesterol, Total	
HDL	HDL	
LDL	LDL	
TRIG	Triglycerides	

URINE ASSAYS

U/M	Urinalysis	
UMACR	Urine Macro	
UMICR	Urine Micro	
CRCL	Creat. Clearance	
UPRT	Protein, Total, Ur	

HEPATIC FUNCTION

ALBAU	Albumin	
ALP	Alk. Phos	
ALT	ALT (SGPT)	
AST	AST (SGOT)	
DBIL	Bilirubin, Direct	
TBIL	Bilirubin, Total	
TP	Protein, Total	

CHEMISTRY/HEMATOLOGY

MARU	Albumin/ Creat Ratio	
AMY	Amylase	
ABSCR	Antibody Screen	
CAION	Calcium, Ionized	
CBC	CBC, only	
CBCSC	CBC w/Auto Diff.	
T4T8P	CD4/CD8 Panel	
CK	Creat Kinase	
FER	Ferritin	
FOLA	Folic Acid	
FSHN1	Follicle Stim Hormone	
GTOL2	Glucose Tolerance (2hrs)	
GLYCH	Glycohemoglobin A1C	
HCGTN	HCG, Quant	
HCT	Hematocrit	
HGB	Hemoglobin	
HGBF3	Hemoglobin, Fecal x3	
HAVM	Hep A IgM	
HAVTO	Hep A Total AB	
HBCAB	Hep B Core AB	
HBSQT	Hep B Surface AB	
HBSAG	Hep B Surface AG	

THYROID TESTING

FT4N1	T4, Free	
TSH	Thyroid Stim. Hormone	
T4	Thyroxine	
T3N1	Triiodothyro. (Total T3)	
TUPN	T-Uptake	

HCVAB	Hep C AB	
HIVAB	HIV AB EIA w/reflex	
HIVPC	HIV PCR (Viral Load)	
HIVG	HIV, Genotype	
FEIBC	Iron & TIBC	
LIPA	Lipase	
LYABE	Lyme AB, EIA (#)	
MG	Magnesium	
PTT	Part. Thrombin Time	
PTN	Phenytoin (Dilantin)	
PHOS	Phosphorus	
PTIN2	Pro. Time (PT w/INR)	
PSASC	PSA Screening Test	
PSAN1	Prostatic Spec. Ag	
RAQL	Rheumatoid Factor (#)	
RPR	RPR (#)	
RUBN1	Rubella Ab, IgG	
SEDRT	Sed Rate	
URIC	Uric Acid	
B12	Vitamin B-12	

OTHER


If requested test is not listed in the Dept of Lab Med Specimen Collection Manual, please provide test name, specimen collection requirements, Reference Lab name, address & phone number

MICROBIOLOGY

Source:	
AFBC	AFB Culture (*)
CTPCR	Chlamydia PCR
C&GSC	Cytospor/Giardia
FDERM	Dermatophyte Culture (*)
FECC	Fecal Culture (*)
FUNGC	Fungal Culture (*)
GCPCR	GC PCR
HSVC	Herpes Culture (*)
O&P	Ova & Parasites w/Stain
STRSN	Strep Screen (*)
THRC	Throat Culture (*)
URC	Urine Culture (*)
VIRC	Viral Culture (*)
WNDC	Wound Culture (*)

FOR LAB USE ONLY

VENI	Phlebotomy by Lab	
OUTV	Outreach Veni	
RVAL	Req Verified	
	ABN	

Do not perform reflex testing for the following test: \_\_\_\_\_  
 (#) Reflex tests, if positive, will be performed at an additional charge (\*) Reflex to Identification and Sensitivity, at additional charge, if indicated

Laboratory testing will not be performed unless all required information is provided on requisition

TESTS IN RED MAY REQUIRE A SIGNED ABN FOR MEDICARE PATIENTS

IF DIAGNOSIS DOES NOT SUPPORT MEDICAL NECESSITY