Holland Hospital
Laboratory Services
602 Michigan Avenue
Holland, MI 49423
Phone (616) 355-3801
Fax (616) 355-3831
CLIA# 23D0666869

DATE COLLECTED	TIME COLLECTED	INITIALS OF COLLECTOR

PATIENT INFORMATION - *Print Clearly*

NAME LAST FIRST INT.

ADDRESS

CITY STATE ZIP CODE

BIRTHDATE | SEX M F | SOCIAL SECURITY NUMBER

ICD-10 DIAGNOSIS CODES (MUST BE INCLUDED)

Provider Signature: _____

ADDITIONAL REPORT TO PROVIDER:

INSURANCE INFORMATION

PROVIDERS SUBMITTING SPECIMEN: PLEASE ATTACH COPY OF INSURANCE CARDS

PATIENT INSTRUCTIONS:

FASTING? ☐ NO
☐ YES: NOTHING TO EAT OR DRINK BUT WATER FOR 12 HOURS PRIOR TO BLOOD DRAW

PSC SITE:_____

HAVE LABWORK DONE ON _____

TEST INSTRUCTIONS:

IF STANDING ORDER: ☐ MONTHLY ☐ WEEKLY ☐ AS DIRECTED
INDICATE FREQUENCY
OTHER _____

INDICATE DURATION
MAX 1 YEAR _____

☐ ROUTINE ☐ ASAP ☐ STAT ☐ CALL ☐ FAX_____

INFECTION CONTROL:

SOURCE PATIENT (CHECK ALL THAT APPLY)
☐ STAT HIV ☐ HEPATITIS B SURFACE ANTIGEN
☐ HEPATITIS C ANTIBODY

EMPLOYEE TESTING (CHECK ALL THAT APPLY)
☐ HIV (NOT STAT) ☐ STORE (DRAW GOLD TUBE) Discard Date_____
☐ HEPATITIS B SURFACE ANTIGEN ☐ HEPATITIS B SURFACE ANTIBODY
☐ HEPATITIS C ANTIBODY

LABORATORY TESTS

- ☐ AMYLASE
- ☐ ANA
- ☐ B12
- ☐ BASIC METABOLIC PANEL (Na, K, Cl, CO2, Creat, BUN, Glu, Ca)
- ☐ BILI-DIRECT
- ☐ BILI-TOTAL
- ☐ CBC
- ☐ CBC W/DIFF
- ☐ CK
- ☐ CHLAMYDIA BY PCR SOURCE:_____
- ☐ COMPREHENSIVE METABOLIC PANEL (Na, K, Cl, CO2, Creat, BUN, Glu, Ca, TP, Alb, AST, ALT, Alk Phos, T.Bili)
- ☐ CORTISOL-AM
- ☐ CORTISOL-PM
- ☐ CREATININE
- ☐ DIGOXIN
- ☐ ESR
- ☐ FREE T3
- ☐ FREE T4
- ☐ FERRITIN
- ☐ FOLIC ACID
- ☐ GC BY PCR SOURCE: _____
- ☐ GLYCO HA1C?
- ☐ HCG-QUAL
- ☐ HCG-QUANT
- ☐ HCT
- ☐ HGB
- ☐ HIV Ag/Ab COMBO
  - ☐ CONSENT FORM SIGNED?
- ☐ H. PYLORI
- ☐ HS-CRP
- ☐ IRON
- ☐ IRON STUDIES (FE, TRANF, TIBC & 0/0 SAT)
- ☐ LIPASE
- ☐ LIPID PANEL (Chol, Trig, HDL, Chol/HDL, calc. LDL)
- ☐ LIPID PLUS (Lipid Panel + Direct LDL if Trig >400)
- ☐ LITHIUM
- ☐ LIVER GROUP- HEPATIC FUNCTION (Alb, Alk Phos, ALT, AST, T. Bili, D. Bili, TP)
- ☐ MAGNESIUM
- ☐ MONO TEST
- ☐ POTASSIUM
- ☐ PROTIME
  IF STANDING ORDER, ENTER FREQ/DUR IN TEST INSTRUCTIONS AREA
- ☐ PSA-DIAGNOSTIC
- ☐ PSA-SCREEN
- ☐ PTT
- ☐ RETIC COUNT
- ☐ RHEUMATOID PANEL (ANA, CRP, RF, Uric Acid, CCP & ESR)
- ☐ RHEUM. FACTOR
- ☐ SEMEN ANALYSIS (INFERTILITY)
- ☐ SEMEN ANALYSIS (POST VASECTOMY)
- ☐ SYPHILIS IGG AB
- ☐ THYROID FUNCTION CASCADE
- ☐ TSH
- ☐ TSH PLUS (TSH, Free T4 if TSH <0.34 OR > 5.01)
- ☐ URIC ACID

OTHER TESTS

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

MICROBIOLOGY TESTS

SOURCE: _____ SITE: _____

- ☐ AEROBIC CULTURE ROUTINE
- ☐ ANAEROBIC CULTURE
- ☐ ACID FAST BACILLUS CULTURE
- ☐ FUNGUS CULTURE
- ☐ HERPES PCR
- ☐ GROUP A STREP SCREEN
- ☐ GROUP B STREP SCREEN
  - ☐ Allergic to Penicillin
- ☐ C. DIFFICILE x____
- ☐ STOOL FOR WBC x____
- ☐ STOOL FOR OCCULT BLOOD x____
- ☐ GIARDIA & CRYPTO x____
- ☐ O and P x____

URINE TESTS

☐ URINALYSIS* ☐ URINALYSIS W/MICROSCOPIC ☐ URINALYSIS W/CULTURE IF INDICATED**
☐ MICROALBUMIN-random ☐ MICROALBUMIN, 24 HOUR
☐ CREATININE, 24 HOUR ☐ TOTAL PROTEIN, 24 HOUR

SOURCE (CHECK ONE)
☐ CREATININE CLEARANCE, 24 HOUR (INCL. BLOOD DRAW) Patient height & weight _____ (Required)
☐ CLEAN CATCH ☐ FOLEY CATH ☐ STRAIGHT CATH ☐ BAGGED URINE

*Microscopic if ind.- Positive leukocyte esterase, blood, nitrite, and/or protein.
**Culture if ind.- Greater than 5 WBC's and /or positive leukocyte esterase.