ERIE COUNTY PUBLIC HEALTH LABORATORY

CLINICAL CENTER, BLDG AA 462 GRIDER STREET, BUFFALO, NY 14215 (716) 898-6100: FAX (716) 898-6110

Clinical Laboratory Requisition

PATIENT INFORMATION

NAME

PATIENT ID NUMBER

ADDRESS

CITY STATE COUNTY ZIP

DATE OF BIRTH PATIENT SEX

GUARDIAN NAME TELEPHONE

PATIENT RACE (Please circle)
1-White 2-Black 3-Native American 4-Asian
5-Other 6-Hispanic 9 Unknown

PROVIDER NAME/LICENSE NO.

FACILITY NAME

REPORTS MAILED TO ADDRESS

ADDRESS

BILLING INFORMATION

INSURANCE COMPANY NAME

INSURANCE ADDRESS

CITY STATE ZIP

POLICY NUMBER

RESPONSIBLE PARTY ADDRESS

DIAGNOSIS (ICD9 DIAGNOSIS CODE) **(Must be provided)**

MEDICAID #

PHYSICIAN SIGNATURE
(Required for all Medicaid Patients)

ECHD PROGRAMS
(Select Primary Reason for Testing)

- ☐ ADULT MED (A)
- ☐ DISEASE CONTROL (D)
- ☐ FAMILY PLANNING (W)
- ☐ GYNECOLOGY (GYN)
- ☐ IMMUNIZATIONS (M)
- ☐ LEAD PROGRAM (L)
- ☐ MIP(B)
- ☐ MOCHA (C)
- ☐ OBSTETRICS (OB)
- ☐ PEDIATRICS (P)
- ☐ PROJECT REACH (E)
- ☐ REFUGEE ASSESS (Q)
- ☐ STD (S)
- ☐ TB (TB)
- ☐ VHIP (V)
- ☐ YOUTH DETENTION(Y)
- ☐ OTHER (Z)______________

SPECIMEN/SOURCE: (Check all that apply) DATE & TIME COLLECTED______________STAFF CODE______________

☐BLOOD,FINGERSTICK	☐CSF	☐RECTAL	☐URINE
☐BLOOD,VENIPUNCTURE	☐FECES	☐THROAT	☐VAGINAL
☐CERVICAL	☐ORAL FLUID	☐URETHRAL	☐OTHER______________

LABORATORY TESTS:

BACTERIOLOGY	CLINICAL CHEMISTRY	HEMATOLOGY	LEAD	SEROLOGY/IMMUNOLOGY
☐Culture-GC	☐Alkaline phosphatase	☐Hematocrit	☐Lead, initial	☐Hepatitis A Ab (IgM)
☐Culture-Group B Strep	☐ALT	☐Sickle Cell Screen	☐Lead, repeat	☐Hepatitis B Core Ab
☐Culture-feces	☐AST		☐Lead, follow-up	☐Hepatitis B Surface Ab
☐Culture-urine	☐Bilirubin, total			☐Hepatitis B Surface Ag
	☐BUN		☐FEP, initial	☐Hepatitis C Ab
☐NAAT:Ct.& GC	☐Cholesterol, total		☐FEP, repeat	
	☐GGT		☐FEP, follow-up	☐HIV-1 Ab
☐Sterility(autoclave)	☐Glucose			☐Rubella
	☐Protein, total			
	☐Uric acid			☐Syphilis Screen
				☐Syphilis Confirm ONLY
	☐Urinalysis w/micro			☐VDRL (CSF ONLY)

SPECIAL REQUESTS/ADDITIONAL INFORMATION:____

CERTIFICATION BY PERSON AUTHORIZED TO ORDER THE HIV TEST

By the signature below, the submitted physician or designee confirms that pre-test counseling has been provided, post-test counseling will be provided and that the patient has given informed consent for the HIV antibody test based on a full explanation of the test and subsequent ramifications including, but not limited to, the following:

1. The test is to determine the presence or absence of antibody to human immunodeficiency virus (HIV)
2. The test for HIV antibody is VOLUNTARY
3. This test is not diagnostic for AIDS. Though most patients with AIDS or the AIDS-related complex (ARC) have antibody to HIV, the reverse is not necessarily true. You may have antibody and not develop AIDS.
4. Repeatedly reactive HIV ELISA screening tests may be evidence of infection and may imply risk to develop AIDS or ARC. All reactive ELISA tests will be confirmed by Western Blot.

Physician or Designee's Signature____

Rev. 06/2003