

# Med2U Order Sheet

Referring Client: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

From (Name): \_\_\_\_\_ Date: \_\_\_\_\_ No. of Pages: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date Of Service: \_\_\_\_\_

Service Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M  F  Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Patient Location:  Residence / Home:  RCFE / ALF  Other: \_\_\_\_\_

Insurance: \_\_\_\_\_ Type: \_\_\_\_\_ Acct. #: \_\_\_\_\_

Results To:  Referring Entity  Physician  Other

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

<b>SERVICE TYPE</b>	<input type="checkbox"/> STAT	<input type="checkbox"/> Routine	<input type="checkbox"/> Fasting	<input type="checkbox"/> Kit Draw: _____	<b>Specimen Pickup Only:</b>
	<input type="checkbox"/> Patient to be drawn at home or facility due to mobility and / or transportation issues	<input type="checkbox"/> PT/INR (Coag)	<input type="checkbox"/> X-Ray	<input type="checkbox"/> X-Ray + EKG	
	<input type="checkbox"/> ECG	<input type="checkbox"/> UA/C&S (UTI Panel)	<input type="checkbox"/> CDiff (GI Panel)		<input type="checkbox"/> UA <input type="checkbox"/> Stool
					<input type="checkbox"/> Other: _____
<input type="checkbox"/> Standing Order:	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Other: _____	End Date: _____

Laboratory Preference: \_\_\_\_\_ Account: \_\_\_\_\_

SELECT ALL TESTS THAT APPLY			
<b>PANELS</b>	<input type="checkbox"/> Phosphorus	<b>THERAPEUTIC</b>	<b>STOOL EVALUATION</b>
<input type="checkbox"/> BMP	<input type="checkbox"/> Hemoglobin A1c	<input type="checkbox"/> Digoxin	<input type="checkbox"/> Fecal Occult Blood
<input type="checkbox"/> CMP	<input type="checkbox"/> Ammonia	<input type="checkbox"/> Dilantin (phenytoin)	<input type="checkbox"/> Culture
<input type="checkbox"/> Lipid Panel	<input type="checkbox"/> BNP <input type="checkbox"/> BNP NTPro	<input type="checkbox"/> Valproic Acid (Depakote)	<input type="checkbox"/> C-Diff <input type="checkbox"/> w/ GI Panel
<input type="checkbox"/> Iron Panel	<input type="checkbox"/> CRP <input type="checkbox"/> High Res	<input type="checkbox"/> Vancomycin	<input type="checkbox"/> O&P
<input type="checkbox"/> Hepatic Function	<input type="checkbox"/> Prealbumin	<input type="checkbox"/> TR <input type="checkbox"/> PK <input type="checkbox"/> RDM	<b>OTHER TEST(S)</b>
<input type="checkbox"/> Renal Function	<input type="checkbox"/> PSA <input type="checkbox"/> Free <input type="checkbox"/> Total	<b>Dose Time:</b> _____	_____
<b>CHEMISTRY</b>	<input type="checkbox"/> T4 <input type="checkbox"/> Free <input type="checkbox"/> Total	<b>URINE EVALUATION</b>	_____
<input type="checkbox"/> CBC w/ Diff <input type="checkbox"/> CBC w/o Diff	<input type="checkbox"/> T3 <input type="checkbox"/> Free <input type="checkbox"/> Total	<input type="checkbox"/> Urinalysis Only	_____
<input type="checkbox"/> Ferritin	<input type="checkbox"/> Vitamin D	<input type="checkbox"/> UA / C&S <input type="checkbox"/> w/ UTI Panel	_____
<input type="checkbox"/> Vitamin B12 <input type="checkbox"/> w/ Folate	<b>COAGULATION</b>	<input type="checkbox"/> Microalbumin / Creatinine	_____
<input type="checkbox"/> ESR (sed rate)	<input type="checkbox"/> Prothrombin Time/INR		_____
<input type="checkbox"/> CPK	<input type="checkbox"/> Venipuncture <input type="checkbox"/> Coag		_____
<input type="checkbox"/> Magnesium	<input type="checkbox"/> PTT Activated		_____

ICD 10 CODES: 

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Ordering Physician: \_\_\_\_\_ NPI#: \_\_\_\_\_