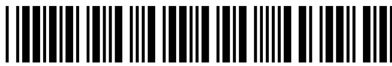


LABORATORY SERVICES
Phone: (831) 625-4811 Fax: (831) 625-4793
J. T. Keating, MD C. L. Hansen, MD D. L. Gardner, MD

MICROBIOLOGY

Last Name: REQUIRED | **First Name:** REQUIRED | **M.I.**

Address: REQUIRED **City** **State** **Zip**

Sex ❑ **M** ❑ **F** REQUIRED | **Date Of Birth:** REQUIRED | **SS#** | **Phone #**

Bill to: ❑ Patient ❑ Facility ❑ Physician ❑ Other (Specify) ____________________
Relationship To Patient: ❑ Self ❑ Other (Name And Address) ____________________
❑ Insurance: ❑ Medicare ❑ Part A ❑ Part B ❑ Medi-Cal ❑ Commercial ❑ Other ____________
Please attach copy of insurance card if appropriate

➔ **Collect Date:** ➔ **Collect Time:**

	Test	CPT Code		**Test**	CPT Code		**Test**	CPT Code
	Urine Culture	87086		Occult Blood (times 3)	82270		H.Pylori Stool Antigen	87338
	Blood Culture	87040		O&P	87177		**Other Test(s)**	
	Stool Culture	87045		Cryptosporidium Antigen	87272			
	Aerobic Culture	87070		Giardia Antigen	87269			
	Anaerobic Culture	87076		Clost. Difficile Toxin	87493		**Special Instructions:**	
	Fungus Culture/ Smear	87102		GC/ Chlamydia-RNA Probe	87491 87591			
				Chlamydia-RNA Probe	87491			
	AFB Culture/Smear	87116		Neisseria Screen	87081			
	Yeast Screen	87101		Herpes Simplex Culture	87254			
	Staph Screen	87081		Beta Strep Screen	87081		**Antibiotic Therapy:**	
	Rapid Strep A Test	87880		Beta Strep Sensitivity, **if allergic to Penicillin**				

➔ **Source:**

❑ Void Urine	❑ Cath. Urine	❑ Blood	❑ Stool	❑ Sputum	❑ Cervix	Other Source (Be Specific)
❑ Rectum	❑ Nose/Nasal	❑ Vagina	❑ Skin	❑ Throat	❑ Wound	

➔ **ICD-10 DIAGNOSIS** REQUIRED:

Results should be: ❑ Called ASAP ❑ Faxed ASAP

(Print Ordering Physician Information Here)

➔ **Authorizing Signature:** REQUIRED **Date:**

❑ **Copied To:** FIRST AND LAST NAME REQUIRED

- LAB USE ONLY -

Specimen / Quantity / Storage	
Room Temp ❑	Refrigerated ❑
Culturette ❑	Anatrans ❑
GC/CHL Vial ❑	Sterile Container ❑
O&P Vial❑	Stool Vial ❑
Other:	
Collector Code:	
Workload Codes:	
Double Checked Initials:	

ACCESSION LABEL

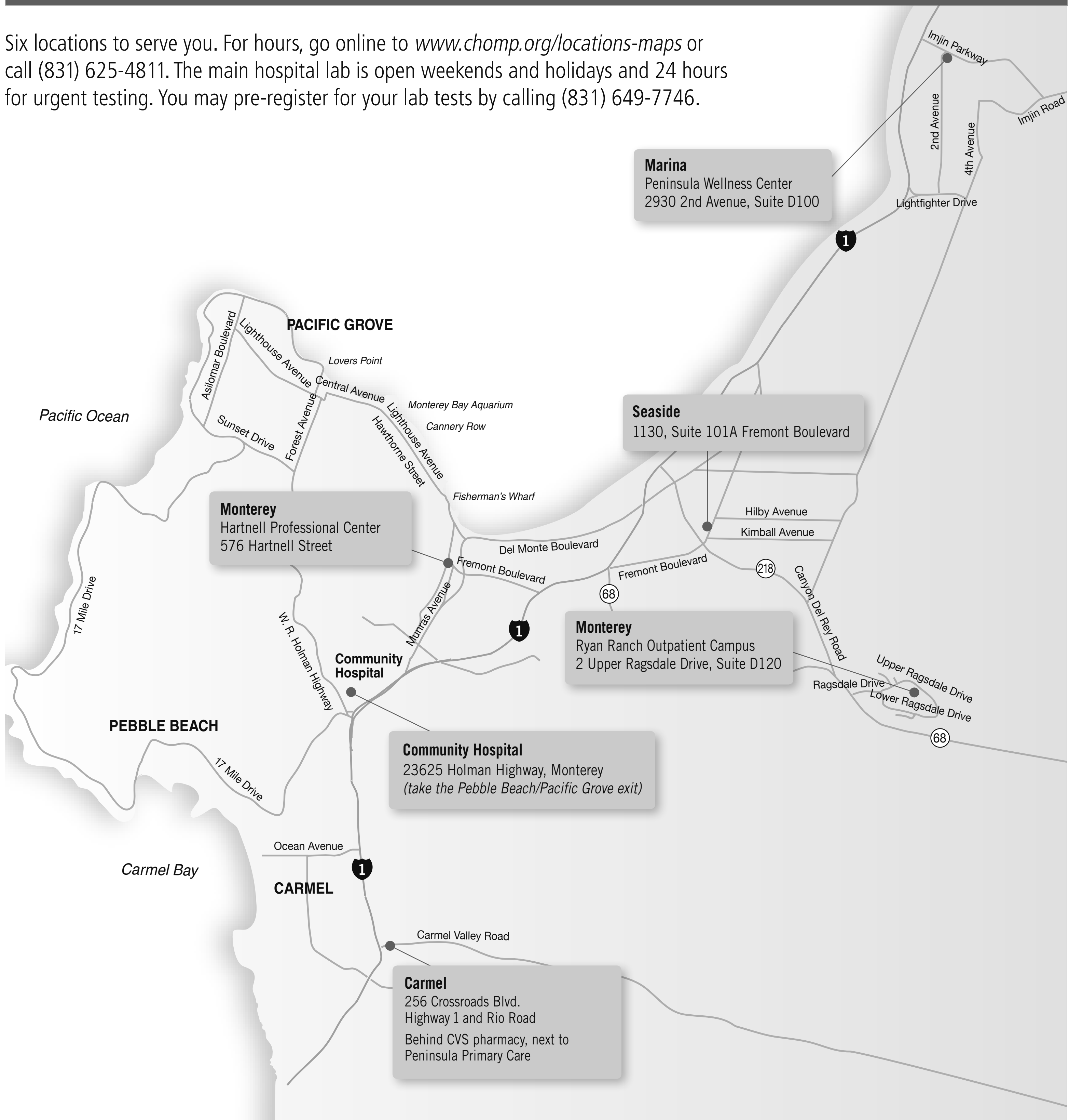
920590 / 7503 (09/15)

Community Hospital of the Monterey Peninsula®

PATIENT STICKER

Community Hospital Laboratories

Six locations to serve you. For hours, go online to *www.chomp.org/locations-maps* or call (831) 625-4811. The main hospital lab is open weekends and holidays and 24 hours for urgent testing. You may pre-register for your lab tests by calling (831) 649-7746.



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Other:		
Collector Code:		
Workload Codes:		
Double Checked Initials:		

920590 / 7503 (09/15)

Community Hospital of the Monterey Peninsula®

PATIENT STICKER

PANELS

BASIC METABOLIC CPT 80048	
ANION GAP	CALCUL.
BUN	84520
GLU	82947
CA	82310
CL	82435
CO2	82374
CREAT	82565
K	84132
NA	84295

ELECTROLYTES CPT 80051	
ANION GAP	CALCUL.
CL	82435
CO2	82374
K	84132
NA	84295

COMP METABOLIC CPT 80053	
ALB	82040
ALK PHOS	84075
ANION GAP	CALCUL.
BILT	82247
BUN	84520
CA	82310
CL	82435
CO2	82374
CREAT	82565
GLU	82947
K	84132
NA	84295
AST	84450
ALT	84460
TOTAL PROTEIN	84155

HEPATITIS, ACUTE CPT 80074	
HAAB	86709
HBcAB IgM	86705
HbsAg	87340
HCV	86803

LIPIDS CPT 80061	
CHOL	82465
HDL	83718
LDL	CALCUL.
TRIG	84478

LIVER FUNCT. CPT 80076	
ALB	82040
ALK PHOS	84075
BILI, DIRECT	82248
BILI, TOTAL	82247
TOTAL PROTEIN	84155
AST	84450
ALT	84460

OBSTETRIC CPT 80055	
ABO TYPE	86900
AB SCREEN	86850
CBC	85025
HBsAg	87340
RH TYPE	86901
RPR	86592
RUBELLA IgG	86762

RENAL FUNCT. CPT 80069	
ALBUMIN	82040
BUN	84520
CALCIUM	82310
CL	82435
CO2	82374
CREAT	82565
GLU	82947
PHOSPHATE	84100
POTASSIUM	84132
SODIUM	84295

REFLEX TESTING: Additional tests added based on conditions of ordered test.

ORDERED TEST	CONDITIONS FOR REFLEXING	Reflexively added test
AFB Smear	Positive	AFB NA Probe
ANAEROBIC CULTURE	Any order for anaerobic culture.	AEROBIC CULTURE
ANA SCREEN	ANA SCREEN = POSITIVE	ANA TITER
CBC w/auto Diff	Automated Diff abnormal, flagged or unable to be performed by analyzer or WBC count <2.0 or >20.0 for Outpatients. WBC >30.0 for inpatients. Basophils >5%, Lymph% >75, or Lymph #>7.	Manual differential
CHOLESTEROL REFLEX	CHOLESTEROL >200 MG/DL	TRIG, HDL, LDL
CKMB if indicated (w/CK)	Abnormal High	CKMB
Cryptococcal Antigen	CSF Source	FUNGUS CULTURE
CULTURE (Any source)	MOST PATHOGENS	ID or confirmatory testing (& SENSITIVITY IF APPLICABLE)
DRUG SCREEN - CHOMP	ANY POSITIVE DRUG SCREEN TEST Except Alcohol	INDIVIDUAL DRUG CONFIRMATIONS
FUNGUS CULTURE	CSF Source	Cryptococcal Antigen
HBsAg	HEPATITIS B SURF. AG = REACTIVE	HBsAg CONF. By Neutralization
HIV	Repeat Reactive	HIV Westernblot
HCG QUANT if indicated (w/HCG)	HCG = POSITIVE	HCG QUANTITATIVE
Syphilis Screen	REACTIVE	TPPA CONFIRMATION
TSH REFLEX	Abnormal High or Abnormal Low	FREE T4
Urine Cult. If Indicated	>= 10 WBCs /hpf, and/or Positive Nitrites and/or Moderate-Many Bacteria	URINE CULTURE
TRANSFUSION:	Based on various conditions, in order to crossmatch units of blood or blood products or to complete patient antibody screen.	Weak D (DU) testing, Antigen typing on patient or unit, Antibody identification, or Direct Coombs.

PLEASE INDICATE ON FORM IN COMMENTS SECTION IF REFLEX TESTING SHOULD *NOT* BE PERFORMED

NOTICE TO PHYSICIANS AND PERSONS LEGALLY AUTHORIZED TO ORDER LAB TESTS: All lab tests for which reimbursement from federally-funded health care programs (Medicare & Medi-Cal) will be sought, must be medically necessary for the diagnosis or treatment of a patient. Medicare generally does not pay for routine screening tests even if the physician considers the tests appropriate for the patient. For the Lab to bill properly and receive payment for tests you have ordered on Medicare and Medi-Cal beneficiaries, the specific ICD-9 or narrative diagnosis(es) must be indicated for each test ordered. It is critical that the diagnosis(es) provided to the Lab is (are) consistent with those recorded in the patients' medical record on the date of service. For any tests ordered that might not be covered on a Medicare or Medi-Cal beneficiary, please complete the form "ABN" – Patient Acknowledgement of Non-Covered Services.