AMERICAN SPECIALTY LAB

CLIA No. 29D102809
NPI 1790191633

RECEIVED BY:_____DATE:_____TIME:_____

www.aslvegas.com
Tel: 702.233.1791 | Fax: 702.233.1793
7251 W. Charleston Blvd
Las Vegas, NV 89117
Dr. Craig A. Voss, MD
Laboratory Director

LAB REQUISITION

Last Name	First Name	D.O.B	FASTING No	Male ☐ Female ☐
Address	City, State, Zip		Phone	

Oder Date		Physician	Primary Ins.
Collected	____/____/_____	Facility	Insurance ID #
Time	____:____ AM/PM	Phone Fax	Secondary Ins.
Technician		NPI	Insurance ID #

ICD-10 CODES | COMMENTS /other DX codes

HEMATOLOGY

- ☐ CBC (w/auto diff)
- ☐ Hematocrit
- ☐ Hemoglobin
- ☐ PTT
- ☐ PT-INR
- ☐ Sedimentation Rate (ESR)

CHEMISTRY

- ☐ Basic Metabolic Panel
- ☐ Comprehensive Metabolic Panel
- ☐ Electrolytes
- ☐ Hepatitis A IgM
- ☐ Hepatitis B Surface Ag
- ☐ Hepatitis B Surface Ab
- ☐ Hepatitis C Ab
- ☐ HIV Ag/Ab Combo
- ☐ Iron TIBC
- ☐ Lipid Panel
- ☐ Liver Panel
- ☐ PSA - Free
- ☐ PSA - Total
- ☐ Renal Panel
- ☐ Rheumatoid Arthritis Factor (RA)
- ☐ Syphilis (RPR)
- ☐ T3 - Free
- ☐ T3 - Total
- ☐ T3 - Uptake
- ☐ T4 - Free
- ☐ T4 - Total
- ☐ Testosterone
- ☐ TSH, 3rd Generation
- ☐ Vitamin B12
- ☐ Vitamin D, 25 Hydroxy

SPECIAL CHEMISTRY

- ☐ Ammonia
- ☐ Amylase
- ☐ Cortisol
- ☐ Ferritin
- ☐ Folate (Folic Acid)
- ☐ FSH and LH
- ☐ Hemoglobin A1c
- ☐ Magnesium
- ☐ Transferrin
- ☐ Uric Acid

DIAGNOSTIC TESTING

- ☐ BNP
- ☐ C - Reactive Protein (CRP)
- ☐ Quantiferon - Gold

DRUG LEVELS

- ☐ Digoxin
- ☐ Dilantin (Phenytoin)
- ☐ Lithium
- ☐ Phenobarbital
- ☐ Theophylline

MICROBIOLOGY and URINE

- ☐ C. DIFF
- ☐ Microalbumin/Creatinine Ratio
- ☐ Occult Blood - Stool
- ☐ Ova and Parasite
- ☐ Total Protein (urine)
- ☐ Urinalysis w/ microscopic
- ☐ Urine Culture
- ☐ URINE DRUG SCREEN (FULL PANEL)

ADDITIONAL TESTS:

Place accession label here

Place accession label here

Place accession label here

I am authorized to order laboratory tests and hereby order the tests indicated below. I confirm these test(s) are medically necessary for the treatment of the patient. I supplied accurate and true information on this form. I am aware information has been supplied to the patient about drug testing and that the patient has consented to the testing through his/her signature on this form. I understand that it is my responsibility to document medical necessity for testing in the patient record and to provide a copy of the same to ASL upon request.

I understand ASL may be out of network with my plan, and I accept responsibility for paying to ASL any amounts my insurer determines are my responsibility after calculating deductibles, co-payments and co-insurance due under my policy. I understand I am legally responsible for sending ASL any money received from my health insurance company for performance of this laboratory test. I also allow the release of medical information necessary to process this claim. I supplied accurate and true information with this form. If I supplied insurance information, I authorize payment of my benefits sent directly to ASL. I authorize to be my Designated Representative and to appeal any denial of health benefits.

Physician Signature:_____Date:_____

Patient Signature:_____ Date:_____