CHINESE HOSPITAL
845 JACKSON STREET
SAN FRANCISCO, CA 94133

OUTPATIENT LABORATORY AND CARDIOPULMONARY ORDER REQUISITION

Laboratory - 415-677-2420 (FAX - 415-677-2442)
CPU - 415-677-2435 (FAX - 415-677-2438)

Locations	Hospital – 845 Jackson Street (H)
Hours	
Monday through Friday	7:30 am – 6:00 pm
Saturday	8:00 am –3:00 pm

Patient Name: ______________________________ **DOB:** ______________
Phone Report to: ______________________ **Send Duplicate Report to:** ______________________
History: (REQUIRED) ______________________________

Laboratory (Hospital locations)

Chemistry
__ Chem 4 - Electrolytes (Na, K, Cl, CO2)
__ Basic Metabolic (Lytes, Gluc, BUN, Creat, Ca)
__ Hepatic Panel (Alb, ALP, ALT, AST, TP, Tbil, Dbil)
__ Comprehensive Metabolic (Lytes, Gluc, BUN, Creat, Ca, TP, ALB, ALP, AST, ALT, Tbil)
__ Lipid Panel (Chol, Trig, HDL, LDL)
__ Acute hepatiis Panel
__ Glucose
__ Hgb A1C
__ TSH with reflex Free T4
__ Iron, TIBC, % Sat.
__ Ferritin
__ Uric Acid
__ Magnesium
__ Phosphorus

Other:
____
____
____
____
____

Hematology
__ CBC (w/diff)
__ CBX (Hemogram)
__ Reticulocyte Count

Cultures
__ Throat
__ Urine
__ Sputum (Number of specimens _____)
__ Other (source ________________)

__Chlamydia (CT) and Gonorrhea (GC) by PCR
__Influenza by PCR

__ Quantiferon TB
__ H. pylori by stool / or breath (cirle)

Hepatitis
__ HBsAG
__ HBsAB
__ HBV DNA
__ HCV Ab
__ Hep A IgG

__HIV Screen
__HSV 1/2
__Hepatitis B Viral DNA Quantatitive

Other
__ Prenatal Panel (Type and screen, CBC, HBsAG, Rubella, RPR, __________)
__ ABO and Rh

__ PT/INR
__ PTT

__ RPR

__ Urinalysis
__ Urine Microalbumin
__ Fecal occult blood by chemsical / or FIT (cirle)
__ Prolactin
__ LH

__ AFP
__ CEA

Cardiopulmonary (May require pre-authorization from insurance) (H location ONLY)

__ EKG
__ Cardiovascular Stress Test
  __ with Nuclear Medicine Studies
  __ Drug Infusion Nuclear Studies
    __ Persantine
    __ Adenosine
  __ Ejection Fraction
  __ Wall Motion
__ Echocardiogram, Transthoracic
__ Stress Echocardiogram

__ 24 Hour Holter Monitor

__ Pulmonary Functions Test
  __ Bronchodilation (Albuterol MDI 3 puffs)
  __ Total Lung Capacity (TLC)
  __ Diffusion Capacity (DLCO)
__ Sputum Induction
  __ AFB
  __ Cytology

__ ABG
  __ Room Air
  __ O_2 @ __________
__ Oximetry at Rest
  __ Room Air
  __ O_2 @ __________
  __ With Exercise

For appointment: 415-677-2435
__ EEG

__ Skin Test
  __ TB

__ UCSF Memory Clinic

__ Procedure, Other: ____________

Diagnosis/Symptoms ICD-10

Diagnosis	ICD-10
__A.S.H.D./CAD	I25.10
__Abnormal EKG	R94.31
__Angina Pectoris	I20.9
__Annual Medical Exam	Z00.00
__Aortic Valve Disease	I35.8
__Asthma	J459.09
__ Atrial Fibrillation Specify:______	I48.91
__ Benign Prostate Hypertrophy	N40.0
__ Bronchitis	J40/J20.9
__ COPD	J44.9
__ Cardiac Arrhythmia	I49.8/I49.1/I49.3
__ Cardiac Murmur	R01.1
__ Cardiomyopathy	I42.8
__Cancer Site:____________ __Benign __Malignant	
__Chest Pain Specify__________	R07.89
__Chronic Renal Failure Stage:__	N18.___
__Cirrhosis	K74.60
__Congestive Heart Failure	I50.9
__Cough	R05
__CVA, old, residual hemiparesis	I699.59
__Diabetes Mellitus	E11.9
__Diabetes Mellitus, Uncontrolled	E11.65
__ Dizziness	R42
__Dysphagia	R13.10
__Dysnpea on exertion	R06.89
__ Edema	R60.9
__Fatigue/Malaise	R53.83/R53.81
__Fever, NOS	R50.9
__Gastritis	K29.70
__Gout	M10.9
__Headache	R51
__Hematuria	R31.9
__Hemoptysis	R04.2
__Hepatitis	K73.9
__Hepatitis B, Chronic	B18.1
__Hyperthyroid	E05.90
__Hypothyroid	E03.9
__ Hypercholesterolemia	E78.00
__ Hyperlipidemia	E78.5
__Hypertension	________
__Impaired blood sugar	R73.01
__ Lung Disease	J98.4
__ MI	I21.__
__ Mitral Valve Disorder	I34.8
__Nausea/Vomiting	R11.0/R11.10/R11.2
__ Otitis Extrema	H60.399
__ Palpitations	R00.2
__Pain Where ______________	________
Pneumonia	J18.9
__ Positive PPD	R76.11
__ Pre-Chemo therapy screening	_____
__Prostate disorder	N42.9
__ Pulmonary Fibrosis	J84.89
__Screening for colon cancer	Z12.11
__Seizure disorder	R56.9
__Shortness of Breath	R06.02
__ Sick Sinus Syndrome	I49.1
__ Syncope	R55
__TB	A15.9
__ TIA	G45.9
__ Tobacco Use Disorde	F17.200
__ Tricuspid Valve Disorder	I36.8
__ Unstable Angina	I20.0
__ UTI	
Other diagnosis ____________	

______________________ Patient's Signature
__ Patient refused to sign

__________ Date

______________________ M.D./D.O./____ **Provider's Signature (REQUIRED)**

__________ **Date**

(Please read Advance Beneficiary Notice on the back page before signing.)