

PHYSICIAN SPECIAL REQUEST

fax: \_\_\_\_\_  email: \_\_\_\_\_

ORDERING PHYSICIAN

By signing below, I hereby certify that I am licensed to order clinical laboratory tests:

PHYSICIAN PRINTED NAME \_\_\_\_\_ X \_\_\_\_\_ PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

LABORATORY USE

OK: \_\_\_\_\_ D: \_\_\_\_\_ STP DBS  
BT ST VOL: \_\_\_\_\_  
REJ: \_\_\_\_\_ D: \_\_\_\_\_ U US  
NEWDR  
PROC AD ML TEST DOB D/C  
SMPL WET UNL QNS EXP KEXP  
INSU ICD9 SIGN BOX  
BILL PCC

PATIENT

PATIENT LAST NAME PLEASE PRINT CLEARLY FIRST NAME PLEASE PRINT CLEARLY M.I. SEX DATE OF BIRTH MM DD YYYY  
ADDRESS  
CITY STATE ZIP DAY PHONE EVENING PHONE

**ICD-9 CODES** highest specificity  
This information is required for insurance billing

PAYMENT

insurance billing  bill physician  credit card  credit card on file  check enclosed  
CREDIT CARD NUMBER CARD EXP. DATE MM YY CHECK NUMBER  
CARDHOLDER NAME PLEASE PRINT CLEARLY AMOUNT (USD)  
X \_\_\_\_\_ CARDHOLDER SIGNATURE \_\_\_\_\_

**SPECIMEN**  
DATE COLLECTED MM DD YY STORAGE PRIOR TO SHIPMENT  
TIME COLLECTED HH : MM AM PM  frozen  refrigerated  
DATE SENT MM DD YY  room temp.

INSURANCE

INSURANCE PROVIDER NAME PHONE  
ADDRESS CITY STATE ZIP  
SUBSCRIBER LAST NAME PLEASE PRINT CLEARLY FIRST NAME PLEASE PRINT CLEARLY M.I. DATE OF BIRTH MM DD YYYY  
RELATIONSHIP TO PATIENT  self  spouse  parent  other: \_\_\_\_\_  
POLICY NUMBER  
MEMBER ID  
GROUP NUMBER  
INSURANCE AGREEMENT: By signing below, I request that payment of all medical benefits be paid directly to US BioTek. I understand that I will be held responsible for any portion of the claim not covered by insurance and any finance charges incurred (18% per annum). I authorize any holder of my personal medical information to release such information necessary for this claim. I further agree that a copy of this original requisition form can be used in place of the original.  
X \_\_\_\_\_ PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

By choosing the **insurance billing** option, you are requesting that we bill your insurance provider for the test service as requested by your physician.  
**For insurance billing, US BioTek requires the following:**  
- check **insurance billing** box  
- complete insurance information  
- complete ICD-9 codes  
- sign **INSURANCE AGREEMENT**  
- copy of insurance card (front and back)

TEST MENU

**IMMUNOLOGY - IgE+IgG**

code	description	sample volume requirement:	serum
96F	96 General Food	5 mL	
96A	96 Asian Food	5 mL	
95V	95 Vegetarian Food	7 mL	
15V	15 Vegetarian Food	2 mL	
48H	24 Herb + 24 Spice	2 mL	
64I	64 Inhalant IgE-only	3 mL	

**IMMUNOLOGY - IgA**

code	description	sample volume requirement:	DBS*	serum
96FA	96 General Food	1	1 mL	
96AA	96 Asian Food	1	1 mL	
95VA	95 Vegetarian Food	2	1 mL	
15VA	15 Vegetarian Food	1	1 mL	
48HA	24 Herb + 24 Spice	1	1 mL	
16IA	16 Inhalant	1	1 mL	

**HORMONE - URINE SAMPLE**

UHP  Urinary Steroid Hormone Profile

The following information is **required** for Urinary Hormone Profile testing.

TOTAL URINE VOLUME \_\_\_\_\_ mL

MEDICATION(S), IF ANY \_\_\_\_\_

FEMALES ONLY  PRE-menopause  POST-menopause LATEST MENSTRUAL CYCLE DATE MM DD (date of the beginning of last menstrual flow)

**IMMUNOLOGY - IgG**

code	description	sample volume requirement:	DBS*	serum
96FG	96 General Food	1	1 mL	
96AG	96 Asian Food	1	1 mL	
95VG	95 Vegetarian Food	2	1 mL	
15VG	15 Vegetarian Food	1	1 mL	
48HG	24 Herb + 24 Spice	1	1 mL	
16IG	16 Inhalant	1	1 mL	

**IMMUNOLOGY - MISC**

code	description	sample volume requirement:	DBS*	serum
CAN	Candida Antibody and Antigen Panel	1	2 mL	
CEL	Celiac Antibody Panel	2	2 mL	
PAP	Painkiller Antibody Panel	2	1 mL	

**CHEMISTRY - URINE SAMPLE**

EPP  Environmental Pollutants Profile

UMP  Urinary Metabolic Profile

See reverse side for additional information

Missing or incomplete information may delay test results. Insufficient specimen may result in the inability to complete testing for all panels ordered.  
There is a \$15 fee for submittal of an unacceptable specimen.