Saddleback Medical Center
24451 Health Center Drive
Laguna Hills, CA 92653
(949)452-3554

ORDER DATE: _____ TIME:

LABORATORY REQUEST
0000

DID YOU REMEMBER... TO INCLUDE DIAGNOSIS CODE(S)?

ALL MD ORDERS: FAX TO 949-452-3563

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED OR CLIENT ACCOUNT MAY BE BILLED.

REMINDER: DON'T FORGET 2 IDENTIFIERS LAST & FIRST NAME AND DATE OF BIRTH

MemorialCare. Saddleback Medical Center

COMPLETE FOR ALL BILLING TYPES (Please attach a copy of MEDI-CARE or Insurance Card)

PATIENT INFO

PATIENT NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH M M / D D / YEAR | AGE | SEX

PATIENT PHONE: ( )

STREET ADDRESS OF INSURED/RESPONSIBLE PARTY

CITY | STATE | ZIP

ORDERING PHYSICIAN**

BILL TO:
- ☐ CLIENT/PHYSICIAN
- ☐ PATIENT
- ☐ CASH PAY
- ☐ MEDICARE (ABN ?)
- ☐ MEDICAID
- ☐ OTHER INSURANCE
- ☐ WORKMAN'S COMP

- ☐ DROP OFF
- ☐ PRE-OP
- ☐ FASTING
- ☐ NON-FASTING

LAB SERVICE LOCATIONS

Saddleback Medical Center
24451 Health Center Dr.
Laguna Hills, CA 92653
Laboratory: (949)452-3554
Pathology: (949)452-3562

STAT

☐ STAT - CALL _____ OR FAX _____ ☐ DURING OFFICE HOURS ONLY TO:

☐ PHONE # _____ ☐ FAX # _____

INSURANCE

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

DATE OF BIRTH M M / D D / YEAR

INSURANCE PTS. ONLY The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the terms of the hospital. The balance unpaid more than 30 days after presentation of the discharge bill or as mutually agreed by third part contract are considered delinquent. Should the account be referred to an attorney for collection the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the rate set by California state law.

****The ordering physician authorizes release of results to Memorial Health System's hospital patient record and subsequently to the patient if requested.**

PATIENT/PARENT/GUARDIAN/CONSERVATOR _____ DATE _____ DATE/TIME COLLECTED: By _____

Diagnosis(es) or Signs/Symptoms for each test: REQUIRED

TESTS	DX CODE
[ ] ALT (SGPT)	
[ ] ANA - Reflex to Titer if ind	
[ ] *APTT - Act Prtl Thromboplast	
[ ] *BHCG Quant	
[ ] *CBC w/diff(scan/man if ind)	
[ ] *CBC - no differential	
[ ] *ESR - Westergreen	
[ ] *Iron Total	
[ ] *HGB A1C	
[ ] *HIV Combo Ab/Ag with conf	
[ ] *PT - Prothrombin Time	
[ ] *PSA - Prostate Spec Antigen	
[ ] Rheumatoid Factor (RA)	
[ ] *T4 Free	
[ ] *TSH	
[ ] *TSH (HS/3rd Gen) rfx to FrT4	
[ ] UA - Urinalysis-microscopic if ind	
[ ] Uric Acid	
***** PROFILES *****	
[ ] Basic Met Panel - *Glu, BUN, Crea, Na K, Cl, CO2, CA*	
[ ] Comp Met Panel - *Basic Met Panel plus Tot Bili, Alkp, SGOT(AST), SGPT(ALT) Tot Protein, Albumin*	
[ ] Hepatic Function Panel - *Alb, Alkp SGOT, SGPT, T&D Bili, Prot*	
[ ] *Lipid Panel - *Trig, Chol, HDL, LDL(calc) VLDL(Calc), Chol/HDL rfx LDL DIR if ind*	
***** OTHER *****	
[ ] Chlamydia & GC	
[ ] Aptima Chlamydia Aptima	
[ ] GC Aptima	
***** MICROBIOLOGY *****	
CULTURES- SENSI if indicated	
[ ] Aerobic-Source:_____	
[ ] Anaerobic-Source:_____	
[ ] GC-Source:_____	
[ ] Throat Culture	
[ ] *Urine Culture	
[ ] Respiratory Culture	
[ ] Viral(susp virus_____)	
[ ] Herpes (M4 Transport Media)	
***** STOOL STUDIES *****	
[ ] C Diff Toxin/Ag with rfx PCR	
[ ] Stool WBC's (Lactoferrin)	
[ ] Occult Blood	
[ ] Stool C&S (Parapak)	
[ ] Giardia Crypto Ag	

LAV _____ ROYAL _____ GRN _____ UA CUP _____ 7 mL RED _____ GRAY _____ BLUE _____ SST _____

YEL _____ SWAB _____ VIRAL TRANSPORT _____ FRESH STOOL _____ STOOL TRANSPORT _____ FROZEN_____

SPUTUM _____ FIOBT _____ OTHER _____

ICD-10 / DIAGNOSIS * *

1. _____
2. _____
3. _____

Person authorized to release Diagnosis information:_____

13635 (10/08/20)

Saddleback Medical Center
24451 Health Center Drive
Laguna Hills, CA 92653
Laboratory: (949)452-3554
Pathology: (949)452-3562

PATHOLOGISTS
Dr. Vivian Mendoza
Dr. Thomas Hirose
Dr. Michelle Fajardo
Dr. Georgia Tunstill
Dr. Nicolas Gallegos

Calif. License No. 206426
Medicare Provider No. M050603
Federal I.D. No. 95-2585792
CLIA No. 05D0578029

ADVANCE BENEFICIARY NOTICE

Medicare will only pay for services that it determines to be medically reasonable and necessary under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular test, although it would otherwise be covered, "is not reasonable and necessary", under the Medicare Program Standards, Medicare will deny payment.

Tests ordered by your physician which are likely to be denied for payment should be identified by the * symbol. By signing the separate acknowledgement form you are agreeing to be financially responsible for payment.