VALLEY DIAGNOSTICS

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"We are a locally owned business."

valleydiagnostics.org

PATIENT NAME: ACCT. # ☐ STAT CALL LAB PT ID # ☐ PRE-OP SURGERY DATE ORDERING PHYSICIAN _____

LAST	FIRST	DATE OF BIRTH	AGE	SEX	DATE COLLECTED	☐ FAST ☐ NFAST	TIME COLLECTED
		/ /		☐ M ☐ F	/ /		

PATIENT ADDRESS	CITY	STATE	ZIP	PATIENT PHONE	PATIENT SSN#

BILL TO → ■ CLIENT ■ PATIENT ■ WORKER'S COMP ■ INSURANCE (SEE BELOW)

MEDICARE	MEDI-CAL	MEDI-CAL MANAGED CARE GROUP NAME & ADDRESS

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP

INSURANCE NAME (IF NOT PATIENT)	INSURED ID#	GROUP#	PLAN	PATIENT RELATIONSHIP TO INSURED	EMPLOYER
				☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	

ADVANCED BENEFICIARY NOTICE - MEDICARE PATIENT'S SIGNATURE REQUIRED

Medicare pays for services it determines to be "reasonable and necessary" under section 182 (a)(1). If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary," Medicare will deny payment for that service. If Medicare denies payment I agree to be personally responsible for payment. Payment denial by Medicare includes the following reasons: Medicare does not pay for routine/exam lab work, does not pay for tests used as a screen to rule out a condition, tests pending FDA approval, tests for the physician's provided diagnosis, same tests within a period of time.

PATIENT'S SIGNATURE _____ DATE _____

ICD-10 DIAGNOSIS CODES REQUIRED →

YOU MAY CHECK APPLICABLE DIAGNOSIS BELOW

R10.9 ABDOMINAL PAIN NOS	E11.9 DIABETES MELLITUS TYPE II, W/O MENTION OF COMPLICATION	E03.9 HYPOTHYROIDISM	J06.9 ACUTE UPPER RESPIRATORY INFECTION, UNSPECIFIED
D64.9 ANEMIA NOS	R53.1 FATIGUE	J18.9 PNEUMONIA, UNSPECIFIED	J22 ACUTE LOWER RESPIRATORY INFECTION, UNSPECIFIED
D50.9 ANEMIA, IRON DEFICIENCY	R31.9 HEMATURIA	N41.1 PROSTATE HYPERPLASIA	CODES FOR UTI COMPLETE
Z00.00 ANNUAL PHYSICAL	E78.0 HYPERCHOLESTEROLEMIA	R35.0 URINARY FREQUENCY	R50.9 FEVER, UNSPECIFIED
M06.9 ARTHRITIS, RHEUMATOID	E78.5 HYPERLIPIDEMIA	E53.8 VITAMIN B-12	N34.1 NONSPECIFIC URETHRITIS
N18.1 CHRONIC RENAL DISEASE	I10 HYPERTENSION BENIGN	E55.9 VITAMIN D DEFICIENCY	N34.2 OTHER URETHRITIS
E10.9 DIABETES MELLITUS TYPE II	E67.3 HYPERVITAMINOSIS D	J20.9 ACUTE BRONCHITIS, UNSPECIFIED	
		J02.9 ACUTE PHARYNGITIS, UNSPECIFIED	

X	Panels	Spec Req
☐	Basic Metabolic Panel ✻ ✓ (Na, K, CL, Bun, glucose, CO2, Creat, Ca)	SST
☐	Comprehensive Metabolic Panel ✻ ✓ ALB, ALT, AST, ALKALP, TP, BILI T Na, K, CL, Bun, glucose, CO_2, Creat, Ca	SST
☐	Electrolyte Panel ✓ (Na, K, CL, CO2)	SST
☐	General Metabolic Panel CMP, CBC, TSH	SST LAV
☐	Hepatic Function Panel ✓ (ALB, ALT, AST, ALKALP, TP, BILI, T&D)	SST
☐	Lipid Panel (CHOL, TRIG, HDL DIRECT, LDL (DIRECT)	SST
☐	CHOL, TRIG, HDL DIRECT	SST
☐	Arthritis Panel Uric Acid, ESR, ANA, RA	1 LAV, 2 SST
☐	Renal Panel BUN, CREA, Na, K, CL, GLU, CO2, AIB, CA, PHOS	SST
☐	Thyroid Panel 1 T3, T4, TSH	SST
☐	Thyroid Panel 2 FT3, FT4, TSH	SST
☐	Endocrinology / Hormone Panel ☐ LH ☐ FSH ☐ Estradiol ☐ Progesterone ☐ Prolactin ☐ DHEA	SST
☐	Respiratory Allergy Region 14 Panel	SST
☐	Food Allergy Panel w/rflx Comp	SST
☐	STD Panel (CT, NG, TV, MG)	U
☐	Respiratory Panel (Influenza A/B, SARS-CoV-2, RSV)	SW
☐	Sore Throat Respiratory Panel (GAS, GCS/GGS, M.pneu, C.pneu, AdV, sCoV, HMPV, HRV/HEV, IAV-H, IAV-H3, IBV, PIV, RSV) ☐ J18.9 ☐ J20.9 ☐ J02.9 ☐ J06.9 ☐ J22	SW

X	Tests (Alphabetical Order)	Spec Req
☐	ABO & RH	L
☐	AB Screen	L
☐	AFP (Non-Preg)	SST
☐	Albumin	SST
☐	ALK PHOS	SST
☐	ALT(SGPT)	SST
☐	Amylase	SST
☐	ANA	SST
☐	ASO	SST
☐	AST(SGOT)	SST
☐	Bilirubin, Direct	SST
☐	Bilirubin, Total	SST
☐	BUN	SST
☐	Calcium	SST
☐	CA125	SST
☐	CBC w/ Platelets & Diff	LAV
☐	CEA	SST
☐	Cholesterol Total † ✻ ✓	SST
☐	CK Total	SST
☐	CO_2	SST
☐	Creatinine, Serum	SST
☐	Chloride	SST
☐	CRP	SST
☐	Cystatin C/GFR	
☐	Digoxin	RED
☐	Dilantin (Phenytoin)	RED
☐	ESR / Sed Rate	LAV
☐	Estradiol	SST
☐	Estrogen	SST
☐	Ferritin ✻	SST
☐	Folate	SST
☐	FSH	SST
☐	GGT	SST
☐	Glucose, Fasting ✻	SST
☐	Glucose, Random ✻	SST
☐	Glucose Tol, Gestational, ____ Hrs	SST
☐	Glucose Tol, Non-Gestational, ____ Hrs	SST
☐	Glycohemoglobin, A1C	LAV
☐	H. Pylori	SST
☐	HCG, Serum (Preg), Qual	SST
☐	HCG Serum, Quant	SST
☐	HCG, Urine (Preg), Qual	SST
☐	HDL Cholesterol ✻	SST
☐	Hemoglobin	LAV
☐	Hepatitis B Surface Antibody	SST
☐	Hepatitis B Surface Antigen	SST
☐	Hepatitis C Antibody	SST
☐	Hepatitis Panel	2 SST
☐	Hep A Ab, Total	SST
☐	Hep B Core Ab, Total	SST
☐	HIV Antibody	SST

X	Tests (Alphabetical Order)	Spec Req
☐	Homocystine	LAV
☐	IFOB	STOOL
☐	Iron	SST
☐	LDH	SST
☐	LDL Direct	SST
☐	Lead, Blood	RB
☐	Lead, Pediatric	RB
☐	LH	SST
☐	Lithium	RED
☐	Magnesium	SST
☐	Mono Test	SST
☐	Parathyroid Hormone	1 SST, 1 LAV
☐	Phenobarbital	RED
☐	Phosphorus	SST
☐	Potassium	SST
☐	Prolactin	SST
☐	Protein, Total	SST
☐	PSA Total ✻	SST
☐	PSA Free	SST
☐	PT (Protime)	B
☐	PTT	B
☐	Reticulocyte Count	LAV
☐	Rheumatiod Factor	SST
☐	RPR (Reflex TPHA) / VDRL ✻	SST
☐	Rubella AB, IgG	SST
☐	Sodium	SST
☐	Tegretol (Carbamazepine)	RED
☐	Theophylline	RED
☐	T4 Total (Thyroxine) ✻	SST
☐	T3 Total	SST
☐	T Uptake ✻	SST
☐	TSH	SST
☐	T4 Free ✻	SST
☐	T3 Free	SST
☐	Testosterone Total	SST
☐	Testosterone Free	SST
☐	TIBC w/Iron ✻	SST
☐	Transferrin	SST
☐	Triglycerides	SST
☐	Uric Acid	SST
☐	Valproic Acid	RED
☐	Vitamin B-12	SST
☐	Vitamin B-12 and Folate	SST
☐	Vitamin D	SST

X	Urine	Spec Req
☐	Urinalysis w/Microscopy + UTI Complete**	U
☐	Urinalysis w/Microscopy (rflx to UTI Complete** or C&S)	U
☐	UTI Complete** Molecular Panel w/ ABR	U
☐	Urinalysis	U
☐	Urine Microscopy	U
☐	Urine for Microalbumin	U
☐	Urine for Protein (Random)	U
☐	Urine for Creatinine (Random)	U
☐	24 Hr. Urine for Protein	U, SST
☐	24 Hr. Urine for Creatinine (Clearance)	U, SST
☐	Urine Drug Screen	U

** UTI Complete is a PCR NAAT that detects 25 Bacterial pathogens and Antibiotic Resistance Gene markers. Includes the Arkstone Antibiotic report.

X	Microbiology	Spec Req
	Source: _____	
☐	STD Panel (Chlamydia, Gonorrhea, Trichomonas, M. Genitalium)	U GP
☐	Culture, Blood ✻	GP
☐	Culture, Group B Strep	CC
☐	Culture, Genital ✻	CC
☐	Culture, Herpes	CC
☐	Culture, Stool ✻	CH/V
☐	Culture, Throat ✻	CB
☐	Culture, Throat Strep Group A	CC
☐	Culture, Urine † ✻	CC
☐	Fungal Culture & Sens	U
☐	Ova & Parasites x _____	
☐	Occult Blood, Stool x _____	SAF
☐	Rapid Strep	CD
☐	Routine C&S, Source	SC
☐	Sputum, Gram Stain/Reflex Culture	SC

Cytology

☐ PAP Smear ☐ VAG ☐ CERV
LMP DATE: _____

NOTE TO PATIENT:

☐ IF BOX IS MARKED, NO FOOD OR DRINK FOR 12 HOURS PRIOR TO LAB WORK

CUSTOM PANELS & TESTS - *Please mark desired panel(s)* ✓ Reflex Testing/Sensitivities performed at an additional charge.

† MEDICARE MAY DENY DUE TO FREQUENCY PARAMETERS
✻ MEDICARE REQUIRES SPECIFIC ICD-10

SEND DUPLICATE REPORT TO _____

Director of Laboratories: David Hadden M.D.

REV 2025-12-11-1357

PHONE / FAX _____