BLOODRUN EXPRESS

BLOOD RUN LAB REQUISITION FAX: (630) 324-0776

TEL: (630) 541-8967 www.bloodrunexpress.com

* PLEASE ATTACHED PATIENT PROFILE *

TODAYS DATE:	**REQUEST DRAW DATE:**
SEX: [ ] MALE [ ] FEMALE	**FREQUENCY: _____ [_____] WEEK [____] MONTH**
PATIENT NAME:	**AGENCY/HEALTH CARE/DR.'s OFFICE PROVIDER NAME:**
DOB: AGE: _____	**REQUESTED BY:**
ADDRESS:	**ADDRESS:**
PATIENT TEL NUMBERS#:	**TEL: FAX:**
INSURANCE NAME: [ ] MEDICARE [ ] BCBS [ ] UHC [ ] AETNA [ ] OTHER _____	**PHYSICANS NUMBER IN CASE OF EMERGENY:**
PRIMARY INSURANCE NO#: **SECONDARY INSURANCE NO#:**	**ORDERING PHYSICIAN AND NPI:** **PRIMARY PHYSICIAN AND NPI:**

FILL DIAGNOSES CODES / ICD-10

1)	2)	3)	4)	5)	6)

NOTE: Only test that are medically necessary for those diagnosis or treatment of the patient may be submitted for Medicare or other insurance reimbursement. Documentation supporting medical necessity must be present in the Patient's medical rec

TEST ORDERED (PLEASE CHECK BOXES)

	PT/INR		**GENERAL HEALTH (CMP/CBC/LIPID/TSH/UA)**		**T-3 TOTAL OR FREE**		**URINALYSIS W/ CS**
	CMP (COMPLETE)		**HEPATITIS PANEL**		**T-4 TOTAL OR FREE**		**WOUND CULTURE W/ ABX RESISTANCE**
	BNP		**RENAL PANEL**		**PSA**		**COVID ONLY RTPCR**
	CBC		**THYROID PANEL**		**CRP**		**COVID AND FLU RTPCR**
	CBC W/ DIFF		**VIT B12**		**URIC ACID**		**RESPIRATORY LITE**
	Ha1C		**VIT D25**		**UA DRUG PANEL**		**RESPIRATORY PLUS**
	TSH		**FERRITIN**		**UA MICROALBUMIN**		**VAGINITIS PANEL**
	ESR (SED RATE)		**FOLATE**		**STOOL CULTURE**		**FUNGAL PANEL**
	LIPID PANEL		**MAGNESIUM**		**C. DIFF**		**INFLUENZA A&B**

***OTHER TESTS/PANELS/INSTRUCTIONS*:**

PRINT REQUESTOR/HC PROVIDER/MD NAME: _____ **SIGNATURE:** _____	**PATIENT'S SIGNATURE:** _____ **I authorize the release to my insurance carrier of any medical information necessary to process this claim and I authorize payment of medical benefits to Blood Run Express. ABN on file in patient record.**

ALL RESULTS SUBJECT TO MINIMUM 24 HOURS RESPONSE FROM TIME OF SPECIMEN DELIVERY OR MORE DAYS FOR SPECIAL TEST(S).