



INSTRUCTIONS FOR GENERAL TEST REQUISITION

General Test Requisition
1622 South Wood Avenue, Linden, New Jersey 07036
(908)862-4404 Fax (908)862-0605

AMMON ANALYTICAL
Laboratory, LLC

<p>ACCT:</p>	<p>Patient Information or Client I.D. Label</p> <p>Last Name First Name MI</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female D.O.B. / /</p> <p>Address (Street) Apt # Floor Room#</p> <p>City State Zip Telephone #</p> <p>Responsible Party/Subscriber Social Security # Client Chart/Pt. ID#</p>
<p>Billing information <input type="checkbox"/> Bill Patient <input type="checkbox"/> Bill Client <input type="checkbox"/> Bill Medicare <input type="checkbox"/> Bill Medicaid <input type="checkbox"/> Bill Insurance <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER</p> <p>Medicare # (Include Prefix/Suffix) Medicaid # State</p>	
<p>INSURANCE</p>	<p>Insurance Company Name Telephone #</p> <p>Subscriber Member # Location Group #</p> <p>Insurance Address Physician's Provider</p> <p>City State Zip</p> <p>I have read the ABN on the reverse. <input type="checkbox"/> Do not bill my insurance.</p> <p><input checked="" type="checkbox"/> _____ Patient's Signature Date</p>
<p>ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED</p> <p>Please check current code</p> <p><input type="checkbox"/> 304.90 Unspecified Drug Dependence</p> <p><input type="checkbox"/> 304.01 Opiate Dependence - Continuous</p> <p><input type="checkbox"/> 304.00 Opiate Dependence - Unspecified</p> <p><input type="checkbox"/> 305.91 Other, mixed or unspecified nondependent drug dependence</p> <p><input type="checkbox"/> Other _____</p>	
<p>Urine Drug Profiles</p>	
<p>Clinical Blood Profiles & Tests</p>	
<p>PROFILES</p> <p>5316 <input type="checkbox"/> ELECTROLYTES Na, K, Cl, CO₂ SS</p> <p>CBMP <input type="checkbox"/> BASIC METABOLIC (BMP) SS <small>Na, K, Cl, CO₂, pH, BUN, Cr, Gl</small></p> <p>C101 <input type="checkbox"/> COMPREHENSIVE METABOLIC (CMP) SS <small>Na, K, Cl, Gl, BUN, Cr, Ca, TP, Abi, TBI, AP, AST, ALT, CO₂</small></p> <p>C102 <input type="checkbox"/> HEPATIC FUNCTION (CHF) SS <small>Abi, TBI, AP, AST, ALT, TP</small></p> <p>CHEV <input type="checkbox"/> LIPID PROFILE Trig, Chol, HDL, LDL, cHDL SS</p> <p>HEP <input type="checkbox"/> HEPATITIS PROFILE HBsAg, HBsAb, HCV SS</p> <p>THYR <input type="checkbox"/> THYROID PROFILE: T4, T3, FT4, TSH SS</p> <p>DIAB <input type="checkbox"/> DIABETIC PROFILE: GLU, HGB A1C GY, LV</p> <p>LMMR <input type="checkbox"/> MMR IMMUNE STATUS PANEL: <small>Measles IgG, Abi, Mumps, Rubella</small></p> <p><input type="checkbox"/> OTHER</p>	<p>TESTS</p> <p>AMYL <input type="checkbox"/> AMYLASE SS</p> <p>FOLA <input type="checkbox"/> FOLATE SS</p> <p>MONO <input type="checkbox"/> HETEROPHILE (MONO) SS</p> <p>SEDR <input type="checkbox"/> SED RATE (ESR) LV</p> <p>ANA <input type="checkbox"/> ANA Screen/WFA SS</p> <p>GGT <input type="checkbox"/> GGT (GGTP) SS</p> <p>HIVA <input type="checkbox"/> HIV-1/2 AB SS</p> <p>FR14 <input type="checkbox"/> T4, FREE SS</p> <p>H101 <input type="checkbox"/> CBC, DIFF, PLT LV</p> <p>CC11 <input type="checkbox"/> GLUCOSE fasting GY</p> <p>LIPA <input type="checkbox"/> LIPASE SS</p> <p>TOT3 <input type="checkbox"/> T3, TOTAL SS</p> <p>CEA <input type="checkbox"/> CEA SS</p> <p>GLYC <input type="checkbox"/> GLYCO High A1c LV</p> <p>LITH <input type="checkbox"/> LITHIUM SS</p> <p>T4 <input type="checkbox"/> T4, TOTAL SS</p> <p>CK <input type="checkbox"/> CK (CK) SS</p> <p>PREG <input type="checkbox"/> HCG Beta sub (GUAN) SS</p> <p>122 <input type="checkbox"/> MICROALBUMIN UA</p> <p>CARB <input type="checkbox"/> TEGRETOL (Carbam) RT</p> <p>CC10 <input type="checkbox"/> CREATININE SS</p> <p>HAVA <input type="checkbox"/> Hep A Total Ab SS</p> <p>PTH <input type="checkbox"/> PARATHYROID LV/SS</p> <p>TSTO <input type="checkbox"/> TESTOSTERONE, Total SS</p> <p>CRP <input type="checkbox"/> CRP QUANT SS</p> <p>HBVS <input type="checkbox"/> Hep B Surface Ag SS</p> <p>PHB <input type="checkbox"/> PHENOBARBITAL RT</p> <p>TSH3 <input type="checkbox"/> TSH SS</p> <p>CRPH <input type="checkbox"/> CRP CARDIO (HS) SS</p> <p>HBAB <input type="checkbox"/> Hep B Surface Ab SS</p> <p>PT <input type="checkbox"/> PT/INR BL</p> <p>2000 <input type="checkbox"/> URINALYSIS UA</p> <p>DIG <input type="checkbox"/> DIGOXIN RT</p> <p>Hep B CORE IgM PTT</p> <p>PTT <input type="checkbox"/> PTT BL</p> <p>VALP <input type="checkbox"/> VALPROIC ACID (DEPAKENE) RT</p> <p>DPH <input type="checkbox"/> DILANTIN RT</p> <p>Hep C Ab SS</p> <p>RHEU <input type="checkbox"/> RF (Rumatoid) SS</p> <p>B12 <input type="checkbox"/> VITAMIN B12 SS</p> <p>FERR <input type="checkbox"/> FERRITIN SS</p> <p>OTHER 101</p> <p>RPR <input type="checkbox"/> RPR SS</p> <p>VITD <input type="checkbox"/> VITAMIN D-25 HYDROXY SS</p> <p><input type="checkbox"/> OTHER</p>
<p>Collection Date _____ Requested By _____ Lab Check _____</p>	
<p><small>CONFIDENTIALITY NOTE: The information contained within this form is privileged and confidential information intended for the use of the individual or entity named above. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this form, or taking any action in reliance upon the contents of this form is strictly prohibited. If you have received this communication in error, please notify us at (908) 862-4404. Destroy all copies and return the original form to us at the address above. Thank you in advance for your cooperation in the matter.</small></p>	

STEP 1: PATIENT INFORMATION



FILLING OUT THE PATIENT INFORMATION BOX IS ESSENTIAL TO THE DRUG SCREENING PROCESS. WITHOUT VERIFYING THE NAME WE WILL NOT BE SURE WHO'S TEST WE ARE RUNNING.

Patient Information or Client I.D. Label				
Last Name		First Name		MI
<input type="checkbox"/> Male <input type="checkbox"/> Female		D.O.B.	/	/
Address (Street)			Apt # Floor Room#	
City	State	Zip	Telephone #	
Responsible Party/Subscriber		Social Security #	Client Chart/Pt. ID#	

Last Name	First Name	MI
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PLEASE FILL OUT THE **PATIENTS NAME CLEARLY.**

STEP 2: BILLING INFORMATION



MAKE A CHECK MARK NEXT TO THE BOX THAT INDICATES **WHO WILL BE GETTING BILLED.**

Billing information Bill Patient Bill Client Bill Medicare Bill Medicaid Bill Insurance

General Test Requisition

AMMON ANALYTICAL LABORATORY

ACCT# _____ Patient Information (w/ Client I.D. Label)

Last Name _____ First Name _____ MI _____

Male _____ Female _____ D.O.B. _____ / /

Responsible Party/Subscriber _____ Social Security # _____ Client Chart/Pt. ID# _____

Billing information Bill Patient Bill Client Bill Medicare Bill Medicaid Bill Insurance SELF SPOUSE CHILD OTHER

Medicare # (Include Prefix/Suffix) _____ Medicaid # _____ State _____

Insurance Company Name _____ Telephone # _____ ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED

Subscriber Member # _____ Location _____ Group # _____ I have read the ABN on the reverse. Do not bill my insurance.

Insurance Address _____ Physician's Provider _____ 304.90 Unspecified Drug Dependence

City _____ State _____ Zip _____ 304.01 Opiate Dependence - Continuous

_____ 304.00 Opiate Dependence - Unspecified

_____ 305.91 Other, mixed or unspecified nondependent drug dependence

_____ Other _____

Urine Drug Profiles

Clinical Blood Profiles & Tests

PROFILES	TESTS
S316 <input type="checkbox"/> ELECTROLYTES (Na, K, Cl, CO ₂) SS	AMYL <input type="checkbox"/> AMYLASE SS
CBMP <input type="checkbox"/> BASIC METABOLIC (BMP) (Na, K, Cl, CO ₂ , Glu, BUN, Cr, Ca) SS	ANA <input type="checkbox"/> ANA Screen/WFA SS
C101 <input type="checkbox"/> COMPREHENSIVE METABOLIC (CMP) (Na, K, Cl, CO ₂ , Glu, BUN, Cr, Ca, TP, Alb, TBil, WBC, ALT, AST, ALP) SS	GGT <input type="checkbox"/> GGT (GGTP) SS
C102 <input type="checkbox"/> HEPATIC FUNCTION (CMP) (Alb, TBil, AP, AST, ALT, TP) SS	CC11 <input type="checkbox"/> GLUCOSE fasting GY
CHEV <input type="checkbox"/> LIPID PROFILE (Trig, Cholesterol, HDL, LDL, cHDL) SS	LV <input type="checkbox"/> GLYCEROL High Alc LV
HEP <input type="checkbox"/> HEPATITIS PROFILE (HBsAg, HBsAb, HCV) SS	LV <input type="checkbox"/> LITHIUM SS
THYR <input type="checkbox"/> THYROID PROFILE (T4, T3, FT4, TSH) SS	LV <input type="checkbox"/> LITHIUM SS
DIAB <input type="checkbox"/> DIABETIC PROFILE (Glu, HbA1c) GYLV	LV <input type="checkbox"/> LITHIUM SS
LMMR <input type="checkbox"/> MMR IMMUNE STATUS PANEL: Rubella (IgG, Abs), Mumps, Subacute) SS	LV <input type="checkbox"/> LITHIUM SS
<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER

Collection Date _____ Requested By _____ Lab Check _____

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STEP 3: INSURANCE INFORMATION



IF THE PATIENTS INSURANCE HAS BEEN CHANGED OR NOT PROVIDED, PLEASE ENTER THIS INFORMATION HERE.

AMMON ANALYTICAL LABORATORY

ACCT: _____ Patient Information (or Chart I.D. Label)

Last Name _____ First Name _____ MI _____

Sex: Male Female Other

Billing information Bill Patient

Medicare # (Include Prefix/Suffix) _____

INSURANCE

Insurance Company Name _____

Subscriber Member # _____

Insurance Address _____

City _____

INSURANCE

Insurance Company Name _____

Subscriber Member # _____ Location _____ Group # _____

Insurance Address _____ Physician's Provider _____

City _____ State _____ Zip _____

Clinical Blood Profiles & Tests														
PROFILES				TESTS										
S316	<input type="checkbox"/> ELECTROLYTES (Na, K, Cl, CO ₂)	SS	AMYL	<input type="checkbox"/> AMYLASE	SS	FOLA	<input type="checkbox"/> FOLATE	SS	MONO	<input type="checkbox"/> HETEROPHILE (MONO)	SS	SEDR	<input type="checkbox"/> SED RATE (ESR)	LV
CBMP	<input type="checkbox"/> BASIC METABOLIC (BMP)	SS	ANA	<input type="checkbox"/> ANA Screen/IgA	SS	GGT	<input type="checkbox"/> GGT (GGTP)	SS	HIVA	<input type="checkbox"/> HIV-1/2 AB	SS	FRT4	<input type="checkbox"/> T4, FREE	SS
C101	<input type="checkbox"/> COMPREHENSIVE METABOLIC (CMP)	SS	HI01	<input type="checkbox"/> CBC, DIFF, PLT	LV	CC11	<input type="checkbox"/> GLUCOSE fasting	GY	LIPA	<input type="checkbox"/> LIPASE	SS	TOT3	<input type="checkbox"/> T3, TOTAL	SS
C102	<input type="checkbox"/> HEPATICFUNCTION (CMP)	SS	GLYC	<input type="checkbox"/> GLYCO High Alc	LV	LITH	<input type="checkbox"/> LITHIUM	SS	TT4	<input type="checkbox"/> T4, TOTAL	SS			
CHEV	<input type="checkbox"/> LIPID PROFILE (Trig, Cholesterol, HDL, LDL, cHDL)	SS	CK	<input type="checkbox"/> CPK (CK)	SS	PREG	<input type="checkbox"/> HCG Beta sub (QUANT)	SS	122	<input type="checkbox"/> MICROALBUMIN	UA	CARB	<input type="checkbox"/> TEGRETOL (Carbam)	RT
HEP	<input type="checkbox"/> HEPATITIS PROFILE (HBsAg, HBsAb, HCV)	SS	CC10	<input type="checkbox"/> CREATININE	SS	HAVA	<input type="checkbox"/> Hep A Total Ab	SS	PTH	<input type="checkbox"/> PARATHYROID	LV/SS	TSTO	<input type="checkbox"/> TESTOSTERONE, Total	SS
THYR	<input type="checkbox"/> THYROID PROFILE (T4, T3, FT4, TSH)	SS	CRPH	<input type="checkbox"/> CRP QUANT	SS	HBVS	<input type="checkbox"/> Hep B Surface Ag	SS	PHB	<input type="checkbox"/> PHENOBARBITAL	RT	TSH3	<input type="checkbox"/> TSH	SS
DIAB	<input type="checkbox"/> DIABETIC PROFILE (GLU, HGB A1C, GYLV)	SS	DIG	<input type="checkbox"/> DIGOXIN	RT	HBAB	<input type="checkbox"/> Hep B Surface Ab	SS	PT	<input type="checkbox"/> PT/INR	BL	2000	<input type="checkbox"/> URINALYSIS	UA
LMMR	<input type="checkbox"/> MMR IMMUNE STATUS PANEL (Rubella IgG Abs, Mumps, Rubella)	SS	DPH	<input type="checkbox"/> DILANTIN	RT		<input type="checkbox"/> Hep C Ab	SS	RHEU	<input type="checkbox"/> RF (Rheumatoid)	SS	B12	<input type="checkbox"/> VITAMIN B12	SS
	<input type="checkbox"/> OTHER		FERR	<input type="checkbox"/> FERRITIN	SS		<input type="checkbox"/> OTHER		101	<input type="checkbox"/> RPR	SS	VITD	<input type="checkbox"/> VITAMIN D-25 HYDROXY	SS
				<input type="checkbox"/> OTHER									<input type="checkbox"/> OTHER	

Collection Date _____ Requested By _____ Lab Check _____

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STEP 4: ADVANCED BENEFICIARY NOTICE (ABN)



THE PATIENT **MUST SIGN THIS FORM**. WITHOUT COMPLETING THIS STEP THIS FORM WILL BECOME INVALID.

I have read the ABN on the reverse.

Do not bill my insurance.

X

Patient's Signature

Date

General Test Requisition
1822 South Wood Avenue, Linden, New Jersey 07036
(908)862-4404 Fax: (908)862-4605

Patient Information (to Clean ID Label)

Last Name: _____ First Name: _____ MI: _____
 Male Female D.O.B. / /
 Address (Street) _____ Apt # Floor Room# _____
 City _____ State _____ Zip _____ Telephone # _____
 Responsible Party/Subscriber _____ Social Security # _____ Client Chart/Pt. ID# _____

Bill Medicare Bill Medicaid Bill Insurance SELF SPOUSE CHILD OTHER
 Medicaid # _____ State _____

Telephone # _____

Group # _____ I have read the ABN on the reverse.
 Do not bill my insurance.

Provider _____

Zip _____ X _____
 Patient's Signature _____ Date _____

ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED
 Please check current code
 304.90 Unspecified Drug Dependence
 304.01 Opiate Dependence - Continuous
 304.00 Opiate Dependence - Unspecified
 305.91 Other, mixed or unspecified nondependent drug dependence
 Other _____

Urine Drug Profiles

Clinical Blood Profiles & Tests															
PROFILES				TESTS											
S316	<input type="checkbox"/> ELECTROLYTES Na, K, Cl, CO ₂	SS		AMYL	<input type="checkbox"/> AMYLASE	SS	FOLA	<input type="checkbox"/> FOLATE	SS	MONO	<input type="checkbox"/> HETEROPHILE (MONO)	SS	SEDR	<input type="checkbox"/> SED RATE (ESR)	LV
CBMP	<input type="checkbox"/> BASIC METABOLIC (BMP) Na, K, Cl, CO ₂ , OH, BUN, Cr, Ca	SS		ANA	<input type="checkbox"/> ANA Screen/IFA	SS	GGT	<input type="checkbox"/> GGT (GGTP)	SS	HIVA	<input type="checkbox"/> HIV-1/2 AB	SS	FRT4	<input type="checkbox"/> T4, FREE	SS
C101	<input type="checkbox"/> COMPREHENSIVE METABOLIC (CMP) Na, K, Cl, BUN, Cr, Ca, TP, Alb, TB, AP, AST, ALT, CO ₂	SS		H101	<input type="checkbox"/> CBC, DIFF, PLT	LV	CC11	<input type="checkbox"/> GLUCOSE fasting	GY	LIPA	<input type="checkbox"/> LIPASE	SS	TOT3	<input type="checkbox"/> T3, TOTAL	SS
C102	<input type="checkbox"/> HEPATIC FUNCTION (CMP) Alb, TB, AP, AST, ALT, TP	SS		CK	<input type="checkbox"/> CK (CK)	SS	PREG	<input type="checkbox"/> HCG Beta sub (QUAN)	SS	122	<input type="checkbox"/> MICROALBUMIN	UA	CARB	<input type="checkbox"/> TEGRETOL (Carbam)	RT
CHEV	<input type="checkbox"/> LIPID PROFILE Trig, Cholesterol, HDL, LDL, cHDL	SS		CC10	<input type="checkbox"/> CREATININE	SS	HAVA	<input type="checkbox"/> Hep A Total Ab	SS	PTH	<input type="checkbox"/> PARATHYROID	LV/SS	TSTO	<input type="checkbox"/> TESTOSTERONE, Total	SS
HEP	<input type="checkbox"/> HEPATITIS PROFILE HBsAg, HBsAb, HCV	SS		CRP	<input type="checkbox"/> CRP QUANT	SS	HBVS	<input type="checkbox"/> Hep B Surface Ag	SS	PHB	<input type="checkbox"/> PHENOBARBITAL	RT	TSH3	<input type="checkbox"/> TSH	SS
THYR	<input type="checkbox"/> THYROID PROFILE: T4, T3, FT4, TSH	SS		CRPH	<input type="checkbox"/> CRP CARDIO (HS)	SS	HBAB	<input type="checkbox"/> Hep B Surface Ab	SS	PT	<input type="checkbox"/> PT/INR	BL	2000	<input type="checkbox"/> URINALYSIS	UA
DIAB	<input type="checkbox"/> DIABETIC PROFILE: GLL, HGB, A1C	GYLV		DIG	<input type="checkbox"/> DIGOXIN	RT		<input type="checkbox"/> Hep B CORE IgM	SS	PTT	<input type="checkbox"/> PTT	BL	VALP	<input type="checkbox"/> VALPROIC ACID (DEPAKENE)	RT
LMMR	<input type="checkbox"/> MMR IMMUNE STATUS PANEL: Rubella IgG, Abs, Mumps, Rubella			DPH	<input type="checkbox"/> DILANTIN	RT		<input type="checkbox"/> Hep C Ab	SS	RHEU	<input type="checkbox"/> RF (Rheumatoid)	SS	B12	<input type="checkbox"/> VITAMIN B12	SS
	<input type="checkbox"/> OTHER			FERR	<input type="checkbox"/> FERRITIN	SS		<input type="checkbox"/> OTHER	SS	101	<input type="checkbox"/> RPR	SS	VITD	<input type="checkbox"/> VITAMIN D-25 HYDROXY	SS
					<input type="checkbox"/> OTHER			<input type="checkbox"/> OTHER			<input type="checkbox"/> OTHER			<input type="checkbox"/> OTHER	

Collection Date _____ Requested By _____ Lab Check _____

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STEP 5: ICD 9 DIAGNOSIS CODE(S)



CHECK THE BOX NEXT TO THE CORRECT CODE(S) FOR THE TESTS THAT ARE BEING ORDERED.

ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED

Please check current code

- 304.90 Unspecified Drug Dependance
- 304.01 Opiate Dependance - Continuous
- 304.00 Opiate Dependance - Unspecified
- 305.91 Other, mixed or unspecified nondependent drug dependence
- Other _____

General Test Requisition

1822 South Wood Avenue, Linden, New Jersey 07036
(908)862-4404 Fax (908)862-4605

Patient Information or Client I.D. Label

Last Name		First Name		MI
<input type="checkbox"/> Male	<input type="checkbox"/> Female	D.O.B.		/ /
Address (Street)			Apt # Floor Room#	
City		State	Zip	Telephone #
Responsible Party/Subscriber		Social Security #		Client Chart/Pt. ID#

Bill Medicare
 Bill Medicaid
 Bill Insurance
 SELF
 SPOUSE
 CHILD
 OTHER

Medicaid # _____ State _____

Telephone # _____

Group # _____

I have read the ABN on the reverse.
 Do not bill my insurance.

Zip _____

Patient's Signature _____
 Date _____

ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED

Please check current code

- 304.90 Unspecified Drug Dependance
- 304.01 Opiate Dependance - Continuous
- 304.00 Opiate Dependance - Unspecified
- 305.91 Other, mixed or unspecified nondependent drug dependence
- Other _____

Urine Drug Profiles

Clinical Blood Profiles & Tests

PROFILES	TESTS	TESTS	TESTS
<input type="checkbox"/> S216 ELECTROLYTES Na, K, Cl, CO ₂ SS	<input type="checkbox"/> AMYL AMYLASE SS	<input type="checkbox"/> FOLA FOLATE SS	<input type="checkbox"/> MONO HETEROPHILE (MONO) SS
<input type="checkbox"/> CBMP BASIC METABOLIC (BMP) Na, K, Cl, CO ₂ , OIL, BUN, Cr, CA SS	<input type="checkbox"/> ANA ANA Screen/IFA SS	<input type="checkbox"/> GGT (GGTP) SS	<input type="checkbox"/> HIV-1/2 AB SS
<input type="checkbox"/> C101 COMPREHENSIVE METABOLIC (CMP) Na, K, Cl, CO ₂ , OIL, BUN, Cr, CA, TP, ALB, TBIL, AST, ALT, ALP, GGT SS	<input type="checkbox"/> H101 CBC, DIFF, PLT SS	<input type="checkbox"/> CC11 GLUCOSE (fasting) GY	<input type="checkbox"/> LIPASE SS
<input type="checkbox"/> C102 HEPATICFUNCTION (CMP) Na, K, Cl, CO ₂ , OIL, BUN, Cr, CA, TP, ALB, TBIL, AST, ALT, ALP, GGT SS	<input type="checkbox"/> CEA SS	<input type="checkbox"/> GLYC GLYCO High Alc LV	<input type="checkbox"/> LITHIUM SS
<input type="checkbox"/> CHEV LIPID PROFILE (Trig, Chl, HDL, LDL, Calc) SS	<input type="checkbox"/> CK (CK) SS	<input type="checkbox"/> HCG Beta sub (QUAN) SS	<input type="checkbox"/> T22 MICROALBUMIN UA
<input type="checkbox"/> HEP HEPATITIS PROFILE (HBAG, HBAB, HCV) SS	<input type="checkbox"/> CC10 CREATININE SS	<input type="checkbox"/> HAVA Hep A Total Ab SS	<input type="checkbox"/> PTH PARATHYROID LW/SS
<input type="checkbox"/> THYR THYROID PROFILE (T4, T3, FT4, TSH) SS	<input type="checkbox"/> CRP CRP QUANT SS	<input type="checkbox"/> HBV Hep B Surface Ag SS	<input type="checkbox"/> PHB PHENOBARBITAL RT
<input type="checkbox"/> DIAB DIABETIC PROFILE (GLU, HBA1C, GYLV) SS	<input type="checkbox"/> CRPH CRP CARDIO (HS) SS	<input type="checkbox"/> HBAB Hep B Surface Ab SS	<input type="checkbox"/> PT/INR SS
<input type="checkbox"/> LMMR IHR IMMUNE STATUS PANEL: Rubeta (IGG, IGM, Mumps, Rubella) SS	<input type="checkbox"/> DIG DIGOXIN RT	<input type="checkbox"/> Hep B CORE Igh RT	<input type="checkbox"/> PTT SS
<input type="checkbox"/> OTHER SS	<input type="checkbox"/> DPH DILANTIN RT	<input type="checkbox"/> Hep C Ab SS	<input type="checkbox"/> RHEU RF (Rumatoid) SS
	<input type="checkbox"/> FERR FERRITIN SS	<input type="checkbox"/> OTHER SS	<input type="checkbox"/> 101 SS
	<input type="checkbox"/> OTHER SS		<input type="checkbox"/> RPR SS
			<input type="checkbox"/> VITD VITAMIN D-25 HYDROXY SS
			<input type="checkbox"/> OTHER SS

Collection Date _____ Requested By _____ Lab Check _____

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STEP 6: IDENTIFYING THE PROCEDURE

General Test Requisition

IDENTIFY THE TEST THAT IS BEING REQUESTED.

AMMON ANALYTICAL

ACCT# _____ Patient Information (w/ Check I.D. Label)

Last Name _____ First Name _____ MI _____

Male Female Other

Billing information Bill Patient

Medicare # (Include Prefix/Suffix) _____

INSURANCE Insurance Company Name _____

Subscriber Member # _____

Insurance Address _____

City _____

Urine Drug Profiles

Clinical Blood Profiles & Tests

PROFILES		TESTS	
S316 <input type="checkbox"/> ELECTROLYTES (Na, K, Cl, CO ₂)	SS AMYL <input type="checkbox"/> AMYLASE	SS FOLA <input type="checkbox"/> FOLATE	SS MONO <input type="checkbox"/> HETEROPHILE (MONO)
CBMP <input type="checkbox"/> BASIC METABOLIC (BMP)	SS ANA <input type="checkbox"/> ANA Screen/IFA	SS GGT <input type="checkbox"/> GGT (GGTP)	SS HIVA <input type="checkbox"/> HIV-1/2 AB
C101 <input type="checkbox"/> COMPREHENSIVE METABOLIC (CMP)	SS H101 <input type="checkbox"/> CBC, DIFF, PLT	LV CC11 <input type="checkbox"/> GLUCOSE fasting	SS LIPA <input type="checkbox"/> LIPASE
C102 <input type="checkbox"/> HEPATIC FUNCTION (CMP)	SS CK <input type="checkbox"/> CEA	SS GLYC <input type="checkbox"/> GLYCO High A1c	LV LITH <input type="checkbox"/> LITHIUM
CHEV <input type="checkbox"/> LIPID PROFILE (Trig, Chol, HDL, LDL, calc)	SS CC10 <input type="checkbox"/> CPK (CK)	SS PREG <input type="checkbox"/> HCG Beta sub (QUAN)	SS 122 <input type="checkbox"/> MICROALBUMIN
HEP <input type="checkbox"/> HEPATITIS PROFILE (HBsAG, HBsAB, HCV)	SS CRP <input type="checkbox"/> CREATININE	SS HAVA <input type="checkbox"/> Hep A Total Ab	SS PTH <input type="checkbox"/> PARATHYROID
THYR <input type="checkbox"/> THYROID PROFILE (T4, T3, FT4, TSH)	SS CRPH <input type="checkbox"/> CRP QUANT	SS HBVS <input type="checkbox"/> Hep B Surface Ag	SS PHB <input type="checkbox"/> PHENOBARBITAL
DIAB <input type="checkbox"/> DIABETIC PROFILE (GLU, HGB A1C)	SS CRPH <input type="checkbox"/> CRP CARDIO (HS)	SS HBAB <input type="checkbox"/> Hep B Surface Ab	SS PT <input type="checkbox"/> PT/INR
LMMR <input type="checkbox"/> MMR IMMUNE STATUS PANEL:	SS DIG <input type="checkbox"/> DIGOXIN	RT <input type="checkbox"/> Hep B CORE IgM	SS PTT <input type="checkbox"/> PTT
<input type="checkbox"/> OTHER	SS DPH <input type="checkbox"/> DILANTIN	RT <input type="checkbox"/> Hep C Ab	SS RHEU <input type="checkbox"/> RF (Rumatoid)
	SS FERR <input type="checkbox"/> FERRITIN	SS <input type="checkbox"/> OTHER	SS 101 <input type="checkbox"/> RPR
	<input type="checkbox"/> OTHER	<input type="checkbox"/> OTHER	SS VITD <input type="checkbox"/> VITAMIN D-25 HYDROXY
			SS <input type="checkbox"/> OTHER

Collection Date _____ Requested By _____ Lab Check _____

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STEP 7: COLLECTION DATE AND CLIENT SIGNATURE

General Test Requisition

FILL OUT THE SPECIMEN COLLECTION DATE AND CONFIRM THE FORM WITH YOUR SIGNATURE.

AMMON ANALYTICAL LABORATORY

ACCT: _____ Patient Information or Client I.D. Label

Last Name _____ First Name _____ MI _____
 Male Female D.O.B. ____/____/____

Billing information Bill Patient
 Medicare # (Include Prefix/Suffix) _____ Medicaid # _____ State _____

INSURANCE: Insurance Company Name _____ Telephone # _____
 Subscriber Member # _____ Location _____ Group # _____
 Insurance Address _____ Physician's Provider _____
 City _____ State _____ Zip _____
 Patient's Signature _____ Date _____

ICD 9 DIAGNOSIS CODE(S) FOR TESTS ORDERED
 Please check current code
 304.90 Unspecified Drug Dependence
 304.01 Opiate Dependence - Continuous
 304.00 Opiate Dependence - Unspecified
 305.91 Other, mixed or unspecified nondependent drug dependence
 Other _____

Urine Drug Profiles

Clinical Blood Profiles & Tests

PROFILES	TESTS	TESTS	TESTS	TESTS
S316 <input type="checkbox"/> ELECTROLYTES (Na, K, Cl, CO ₂) SS	AMYL <input type="checkbox"/> AMYLASE SS	FOLA <input type="checkbox"/> FOLATE SS	MONO <input type="checkbox"/> HETEROPHILE (MONO) SS	SEDR <input type="checkbox"/> SED RATE (ESR) LV
CBMP <input type="checkbox"/> BASIC METABOLIC (BMP) SS Na, K, Cl, CO ₂ , GLU, BUN, Cr, Ca	ANA <input type="checkbox"/> ANA Screen/IgA SS	GGT <input type="checkbox"/> GGT (GGTP) SS	HTLV <input type="checkbox"/> HIV-1/2 AB SS	FRT4 <input type="checkbox"/> T4, FREE SS
C101 <input type="checkbox"/> COMPREHENSIVE METABOLIC (CMP) SS Na, K, Cl, CO ₂ , BUN, Cr, TP, ALB, TBIL, WBC, HGB, ALT, AST, GGT	HI01 <input type="checkbox"/> CBC, DIFF, PLT LV	CC11 <input type="checkbox"/> GLUCOSE fasting SS	LIPA <input type="checkbox"/> LIPASE SS	TOT3 <input type="checkbox"/> T3, TOTAL SS
C102 <input type="checkbox"/> HEPATIC FUNCTION (CMP) SS ALB, TBIL, AP, AST, ALT, TP	CEA <input type="checkbox"/> CEA SS	GLYC <input type="checkbox"/> GLYCO High Alc LV	LITH <input type="checkbox"/> LITHIUM SS	TT4 <input type="checkbox"/> T4, TOTAL SS
CHEV <input type="checkbox"/> LIPID PROFILE (Trig, Cholesterol, HDL, LDL, cHDL) SS	CK <input type="checkbox"/> CPK (CK) SS	PREG <input type="checkbox"/> HCG Beta sub (QUAN) SS	122 <input type="checkbox"/> MICROALBUMIN UA	CARB <input type="checkbox"/> TEGRETOL (Carbam) RT
HEP <input type="checkbox"/> HEPATITIS PROFILE (HBsAg, HBsAb, HCV) SS	CC10 <input type="checkbox"/> CREATININE SS	HAVA <input type="checkbox"/> Hep A Total Ab SS	PTH <input type="checkbox"/> PARATHYROID LV/SS	TSTO <input type="checkbox"/> TESTOSTERONE, Total SS
THYR <input type="checkbox"/> THYROID PROFILE: T4, T3, FT4, TSH SS	CRPH <input type="checkbox"/> CRP QUANT SS	HBVS <input type="checkbox"/> Hep B Surface Ag SS	PHB <input type="checkbox"/> PHENOBARBITAL RT	TSH3 <input type="checkbox"/> TSH SS
DIAB <input type="checkbox"/> DIABETIC PROFILE: GLU, HGB, A1C, GYLV SS	CRPH <input type="checkbox"/> CRP CARDIO (HS) SS	HBAB <input type="checkbox"/> Hep B Surface Ab SS	PT <input type="checkbox"/> PT/INR BL	2000 <input type="checkbox"/> URINALYSIS UA
LMMR <input type="checkbox"/> MMR IMMUNE STATUS PANEL: Rubella IgG, Abc, Mumps, Rubella SS	DIG <input type="checkbox"/> DIGOXIN RT	Hep B CORE IgM <input type="checkbox"/> Hep B CORE IgM RT	PTT <input type="checkbox"/> PTT BL	VALP <input type="checkbox"/> VALPROIC ACID (DEPAKENE) RT
<input type="checkbox"/> OTHER _____	DIPH <input type="checkbox"/> DILANTIN RT	Hep C Ab <input type="checkbox"/> Hep C Ab SS	RHEU <input type="checkbox"/> RF (Rheumatoid) SS	B12 <input type="checkbox"/> VITAMIN B12 SS
	FERR <input type="checkbox"/> FERRITIN SS	<input type="checkbox"/> OTHER _____	101 <input type="checkbox"/> RPR SS	VITD <input type="checkbox"/> VITAMIN D-25 HYDROXY SS
	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> OTHER _____

Collection Date _____ Requested By _____ Lab Check _____

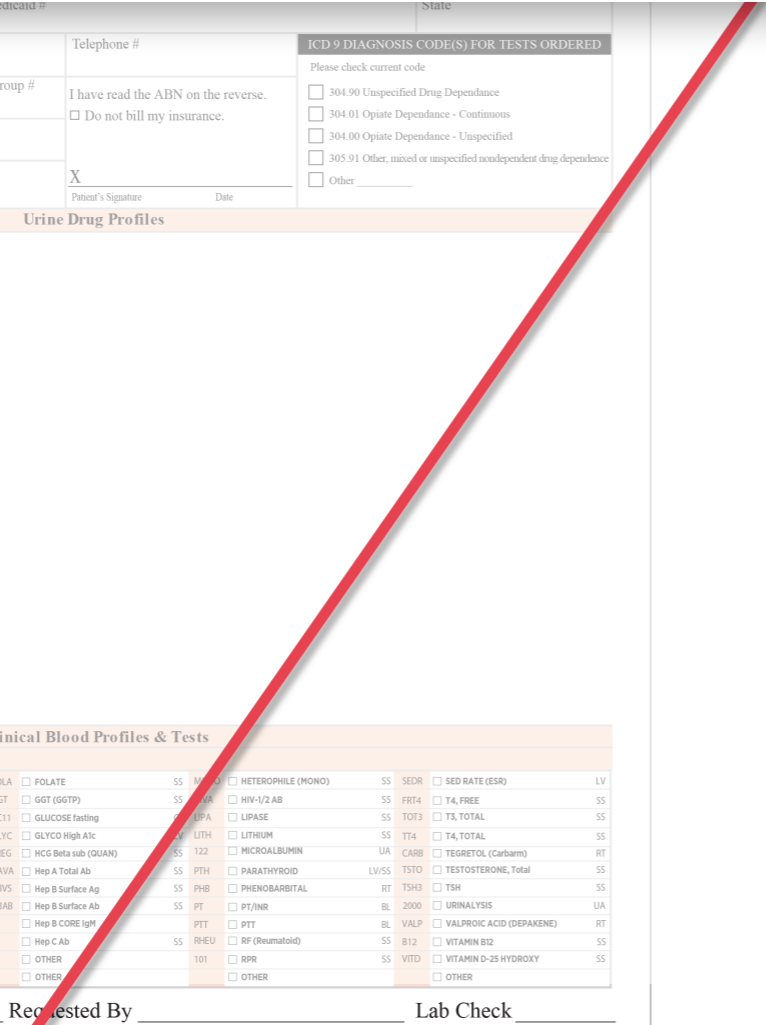
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