



NORTH SHORE MEDICAL CENTER

Salem Hospital
81 Highland Avenue, Salem, MA 01970
(978) 354-4134 / Fax: (978) 740-4866 (Main Lab)
(978) 740-4843 (Outpatient drawing station fax)

Union Hospital
500 Lynnfield Street, Lynn, MA 01904
(781) 581-9200, x3456 / Fax: (781) 596-8407 (Main Lab)

Date to be drawn:
Room #:
Called to Lab:
Date & time drawn:
Phleb. Id.
Orders received by:

PATIENT NAME:
ADDRESS:
SOC. SEC. #:
TELEPHONE:
D.O.B.:
SEX
UNIT NO.:
RESPONSIBLE PARTY:
INSURANCE:
MEDICAID PATIENTS REQUIRE PHYSICIAN'S SIGNATURE:

Need patient labels

ORDERING PHYSICIAN:
ADDRESS:
TELEPHONE #:
COPY TO PHYSICIAN:
ADDRESS:

PROVIDE ICD-9 CODES FOR ALL TESTS ORDERED.
Diagnosis (ICD9-Code):
and/or signs and symptoms
It is strongly recommended that all tests are ordered individually based on medical necessity.

SEE BACK OF THIS PAGE FOR MEDICARE NOTICE ON NON-COVERAGE (MNNC) - COMPLIANCE IS MANDATORY AND REGULATED

For the laboratory to bill properly and receive payment for test(s) you have ordered you must include the specific ICD-9 code(s) or a descriptive diagnosis on each patient and for each test ordered. It is critical that the diagnosis you provide to the lab is consistent with those recorded in the patient's medical record on the date of service. Carriers now require that the same diagnosis be consistent with the ordering physician and the performing laboratory. See back of this page for additional information and the Medicare Notice of Non-Coverage.

- COMPREHENSIVE METABOLIC
BASIC METABOLIC PANEL
DIABETIC PANEL
PRENATAL PANEL
LIVER PANEL
ELECTROLYTES
LIPID PANEL
RENAL PANEL

- DEPAKENE
DIGOXIN
DILANTIN
DRUG-ANALYSIS, URINE (Non-NIDA approved only.)
ETHANOL URINE
FERRITIN
FSH
FOLATE
GGT
GLUCOSE FASTING
GLUCOSE RANDOM
GLUCOSE 1 HR
GLUCOSE 2 HR
GTT 3 HR
HCG (Beta Subunit)
HDL
HEMOGLOBIN A1C (lav. top)
HEPATITIS A ANTIBODY (ANTI-HAV)
HEPATITIS B CORE ANTIBODY (HBcAB)
HEPATITIS B SURF ANTIBODY (HBsAB)
HEPATITIS B SURF ANTIGEN (HBsAG)
HEPATITIS C ANTIBODY
HIV (Consent form filed where blood is drawn.)
HOMOCYSTEINE
IRON
LEAD (Lavender Top)
LIPASE
MAGNESIUM
PHENOBARBITAL
PHOSPHORUS
POTASSIUM
PSA
FREE PSA
PSA SCREENING
SODIUM
TEGRETOL
TESTOSTERONE
THEOPHYLLINE
TOTAL PROTEIN
TOTAL T3
TRIGLYCERIDE
TROPONIN (green top)
TSH
T4
FREE T4
URIC ACID

- HEMATOLOGY (Lavender Top - Unless Noted)
PROTIME (blue top)
HEMATOCRIT
SED RATE (blue top)
APTT (blue top)
HEMOGLOBIN
EO COUNT
CBC
RETIC COUNT
PLATELET COUNT
CBC / DIFF
FACTOR II 20210 G>A (Prothrombin Gene Mutation)

- SEROLOGY (SST Tube)
ANA
RA FACTOR
RUBELLA
ASO
RUBEOLA IgG
MUMPS IgG
H. PYLORI
RPR
VARICELLA IgG
MONO TEST
LYMES SCREENING

- MICROBIOLOGY
Tests (Sensitivity performed when required)
Throat Strep A Culture
Fungus Culture
Routine Culture
Throat Culture
Genital Strep B
Blood Culture
Rapid Strep A Antigen
Gen Probe, Chlamydia
Stool Culture
Sputum Culture (no wooden swabs)
Ova + Parasites
TB Culture & Smear
Gen Probe, GC
Giardia Antigen
Urine Culture (no wooden swabs)
C. Difficile Toxin
Genital Culture
Herpes Culture
(no wooden swabs)

- Source
Cervix
Throat
Urine-CVC
Urine-Cath.
Blood
Penis
Eye
Ear
Vagina
Sputum
Stool

- BLOOD BANK (Pink Top)
TYPE & SCREEN, PRENATAL
Rh IMMUNE GLOBULIN SET UP
TYPE & SCREEN, PRE-TRANSFUSION
UNITS, COMPONENT
TRANSFUSION DATE
LOCATION

- CHEMISTRY (SST Tube unless noted)
ALBUMIN
ALK PHOS
ALPHA-FETOPROTEIN
ALT/SGPT
AMYLASE
AST/SGOT
B-12
BILIRUBIN, TOTAL
BILIRUBIN, TOTAL & DIR.
BUN
CA 15-3
CA 27.29
CA 19-9
CA-125
CALCIUM
CEA
CHLORIDE
CHOLESTEROL, TOTAL
CO2
CPK
CREATININE, eGFR
CRP, INFLAMMATION
CRP, CARDIO RISK

- URINE / FECES
URINE FOR MICROALBUMIN
URINALYSIS (Add microscopic if Dip Stick screen positive)
FECAL OCCULT BLOOD (Guaiac)
24 Hour Urine

- OTHER TESTS / REQUESTS

200010-D (10/05)

LAB COPY

**HOURS OF OPERATION**

*Salem Hospital*

*North Shore Children's Hospital*

*Union Hospital*

Laboratory, Davenport 4-Fax: (978) 740-4843  
7:00 a.m.-5:30 p.m., Mon.-Fri. / 7:00 a.m.-12:00 p.m. Sat.

1st Floor (978) 745-2100 NSCH Lab Fax: (978) 825-6985  
8:00 a.m.-5:30 p.m., M-F / 8:00 a.m.-3:00 p.m., Sat.-Sun.

Main Hospital, 1st Floor - Fax: (781) 596-8407  
7:00 a.m.-4:00 p.m., Mon.-Sat.

Patient's Name: \_\_\_\_\_

Medicare # (HICN): \_\_\_\_\_

# ADVANCE BENEFICIARY NOTICE (ABN)

**NOTE:** You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimated Cost: \$ \_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.**

**Option 1. YES. I want to receive these laboratory tests.**  
 I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making the decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

**Option 2. NO. I have decided not to receive these laboratory tests.**  
 I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of patient or person acting on patient's behalf

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-L (June 2001)



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Herpes Culture
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AMYLASE
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B-12
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BILIRUBIN, TOTAL & DIR.
BUN
CA 15-3
CA 27.29
CA 19-9
CA-125
CALCIUM
CEA
CHLORIDE
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