

**Laboratory Test Form**

Patient Name: \_\_\_\_\_ Exam Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ Exam Time: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Referring Physician Phone: \_\_\_\_\_ SS# \_\_\_\_\_  
Referring Physician Signature: \_\_\_\_\_ Referring Physician Fax: \_\_\_\_\_  
Symptoms/Diagnosis: \_\_\_\_\_  
Allergies: \_\_\_\_\_

*Please bring all insurance information with you.*

**ORGAN/DISEASE PANELS:**

- |  |   |
|--|---|
| <input type="checkbox"/> ELECTROLYTE PANEL     | <input type="checkbox"/> HEPATIC FUNCTION PANEL |
| <input type="checkbox"/> BASIC METABOLIC PANEL | <input type="checkbox"/> CMP                    |
| <input type="checkbox"/> METABOLIC PANEL       | <input type="checkbox"/> LIPID PANEL            |

**HEMATOLOGY:**

- CBC w/ DIFF ( H/H, RBC, Indices, WBC, PLT, DIFF)
- PT with INR
- PTT, ACTIVATED

**OTHER TESTS:**

- |  |   |
|--|---|
| <input type="checkbox"/> ANA w/ REFLEX TITER | <input type="checkbox"/> SED RATE BY MOD WEST               |
| <input type="checkbox"/> C-REACTIVE PROTEIN  | <input type="checkbox"/> TSH                                |
| <input type="checkbox"/> CA 125              | <input type="checkbox"/> T-3 TOTAL                          |
| <input type="checkbox"/> CREATININE (Cr)     | <input type="checkbox"/> T-4 (THYROXINE) TOTAL              |
| <input type="checkbox"/> FSH                 | <input type="checkbox"/> FREE T-3 34429                     |
| <input type="checkbox"/> GLUCOSE, SERUM      | <input type="checkbox"/> T-4 (THYROXINE), FREE              |
| <input type="checkbox"/> HCG, SERUM, QUANT   | <input type="checkbox"/> UA- complete (dipstick & micropic) |
| <input type="checkbox"/> HEMOGLOBIN A1C      | <input type="checkbox"/> UREA NITROGEN (BUN)                |
| <input type="checkbox"/> LH                  | <input type="checkbox"/> VITAMIN B12                        |
| <input type="checkbox"/> RHEMATOID FACTOR    |   |

- |                                   |                              |
|-----------------------------------|------------------------------|
| <input type="checkbox"/> CBC      | <input type="checkbox"/> IgM |
| <input type="checkbox"/> CMC      | <input type="checkbox"/> IgA |
| <input type="checkbox"/> CEA      | <input type="checkbox"/> IgG |
| <input type="checkbox"/> CA 15.3  |                              |
| <input type="checkbox"/> CA 27.29 |                              |
| <input type="checkbox"/> CA 125   |                              |

---

**Confidentiality Statement:** The information contained in the material is privileged and is intended only for the use of the individual(s) or entity named above. If you are not the intended recipient, be advised that any unauthorized disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited.

**Please send all previous exams and reports to our office prior to the schedule exam.**

We are referring you to Future Diagnostic Group (FDG), LLC imaging facility to have your ordered scan(s) performed. Please note that we have an indirect financial relationship with this facility. You are under no obligation to have your testing performed at this facility.