River Town Diagnostics

River Town Diagnostics
Address: 8563 Argyle Business loop ste 2
Jacksonville, FL 32244 Phone: (904) 619–9299
Email: support@rivertowndx.net CLIA# 10D2173247

PRACTICEINFORMATION

BLOOD AND HORMONE REQUISITION FORM Please see Reverse side to Complete Form

PATIENT INFORMATION *IMPORTANT-Include a current medication list AND a patient fact sheet OR complete next two sections below and include photo copy of insurance card (front and back).*

First Name	Last Name	Phone Number	Biological Sex ☐ F ☐ M
DOB(MM/DD/YYYY)	DOD (if applicable)	Email	Fasting ☐ Yes ☐ No
Address	City	State	ZIP

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown
Race: ☐ American Indian/AlaskaNative ☐ Asian ☐ Black/African American ☐ Multi Race ☐ Native Hawaiian/Pacific island ☐ White ☐ Other

PATIENT INSURANCE INFORMATION - *Attach patient demographics and copy of insurancecard*

☐ Medicare ☐ Commercial ☐ Medicaid

SPECIMEN INFORMATION

TESTORDER: *PLEASE MAKE A PANEL SELECTION FROM THE FOLLOWING LIST:* *SPECIMEN: SST=TIGER TOP U=URINE CUP L=LAVENDAR*

CHEMISTRY

82040	☐ Albumin	SST
84075	☐ Alk. Phos.	SST
84460	☐ ALT/SGPT	SST
82150	☐ Amylase	SST
84450	☐ AST/SGOT	SST
82247	☐ Bilirubin,Total	SST
84520	☐ BUN	SST
82310	☐ Calcium	SST
82374	☐ Carbon Dioxide	SST
82465	☐ Cholesterol, Total	SST
82435	☐ Chloride	SST
82550	☐ CK	SST
82565	☐ Creatinine, Serum	SST
86140	☐ CRP-HS	SST
82728	☐ Ferritin	SST
82746	☐ Folate	SST
82977	☐ GGT	SST
82947	☐ Glucose	SST
82950	☐ Glucose Tolerance, 1 HR	SST
82951	☐ Glucose Tolerance, 3HR	(4)-SST
82952	fasting, 1HR, 2HR, 3HR	
83036	☐ Hemoglobin A1C	L
83525	☐ Insulin	SST
83540	☐ Iron	SST
83540/ 83550	☐ Iron/TIBC	SST
83735	☐ Magnesium	SST
84100	☐ Phosphorus	SST
84132	☐ Potassium	SST
84478	☐ Triglycerides	SST
84550	☐ Uric Acid	SST
83550	☐ UIBC	SST
84295	☐ Sodium	SST
84155	☐ Total Protein	SST
82607	☐ Vitamin B12	SST
82306	☐ Vitamin D, 25-OH	SST

PANELS

80048	☐ BMP	SST
80053	☐ CMP	SST
80051	☐ ELECTROLYTES	SST
80076	☐ HEPATIC PANEL	SST
80061	☐ LIPID PANEL	SST
80069	☐ RENAL PANEL	SST

HORMONES

82533	☐ Cortisol	SST
82627	☐ DHEA-S	SST
82670	☐ Estradiol	SST
84403/ 84270	☐ Testosterone,Free Testosterone, Total	SST
83001	☐ FSH	SST
83002	☐ LH	SST
84144	☐ Progesterone	SST
84146	☐ Prolactin	SST
84153	☐ PSA, Diagnostic	SST
84270	☐ SHBG	SST
84481	☐ T3,Free	SST
84480	☐ T3,Total	SST
84439	☐ T4,Free	SST
84436	☐ T4,Total	SST
84403	☐ Testosterone	SST
84479	☐ Thyroid Uptake	SST
84443	☐ TSH	SST
86376	☐ TPO	SST
84153	☐ PSA, Free & Total	SST
84154	☐ PSA, Diagnostic (Total only)	SST

COAGULATION

85027	☐ CBC	L
85025	☐ CBC w/Diff	L

DIAGNOSIS (ICD-10) CODES

Primary Dx Code(s) _____
_____
_____

Secondary Dx Code(s) _____
_____
_____

Tertiary Dx Code(s) _____
_____
_____

☐ BPH	N40.0
☐ Elevated PSA	R97.2
☐ Hormone Disorder,unspec.	E34.9
☐ Hypothyroidism,unspec.	E03.9
☐ Hyperparathyroidism, unspec.	E21.3
☐ Hypoparathyroidism, unspec.	E20.9
☐ Hypoactive Sexual Desire	R52.0
☐ Impotence	N52.9
☐ Low Libido	R68.82
☐ Major Depressive Disorder, unspec., single episode	F32.9
☐ Major Depressive Disorder, unspec., Recurrent	F33.9
☐ Malignant Neoplasm of Prostate	C61
☐ Menopause	N95.1
☐ Menopausal/Perimenopausal Disorder	N95.9
☐ Neurosis, unspec.	F48.9
☐ Prostate Cancer Screening	Z12.5
☐ Psychosis, unspec.	F29
☐ Psychosexual Dysfunction	R37
☐ Testicular Dysfunction, unspec.	E29.9
☐ Thyroid Disorder, unspec.	E07.9
☐ Abnormal Weight Gain	R63.5
☐ Cushing Syndrome	E24.9
☐ Metabolic Syndrome	
☐ Metabolism, Endocrine, NOS Disorder, unspec.	E34.9
☐ Malnutrition, moderate	E44.0
☐ Nutritional Deficiency	E63.9
☐ Obesity, unspec.	E66.9
☐ Primary Adrenocortical Insufficiency	E27.1
☐ Abnormal Kidney Function, NOS	R94.4
☐ Abdominal Tenderness	R10.819
☐ Abdominal Pain, NOS	R10.9
☐ Biliary Colic	K80.50
☐ Chronic Nonalcoholic Liver Disease, NOS	K76.9
☐ Chronic Kidney Disease, NOS	N18.9
☐ Abnormal Chest X-ray	R91.8
☐ Chronic Bronchitis	J41.0
☐ Cough	R05
☐ Dyspnea	R06.00
☐ Lung Disease, NOS	J98.4
☐ Shortness of breath	R06.02
☐ Sleep Apnea	G47.39
☐ Osteoporosis, NOS	M81.0

PHYSICIAN AUTHORIZATION

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom. By submitting this physician order form, I acknowledge the test(s) ordered are medically necessary and reasonable for diagnostics and treatment decision. I acknowledge only medically necessary testing should be ordered. As a provider, I acknowledge that the requested test(s) are medically necessary, and a written order is contained in the patient's records

Authorizing Provider Name	Authorizing Provider NPI#
Authorizing Provider Signature	Date

DIAGNOSIS (ICD-10) CODES *Select or write-in one or more codes from the spaces / selections below (REQUIRED)*

DIAGNOSTIC CODES REQUIRED: Please check all codes that apply with testing and write additional codes at the bottom of this form. This is not an all-inclusive list.

CARDIOVASCULAR

Angina, unspec.	I20.9
Atrial Fibrillation, unspec.	I48.91
Cardiovascular Disease	I51.9
Chest Pain, NOS	R07.9
Congestive Heart Failure	I50.9
Family History of CAD	Z82.49
Hypertension	I10
Hypercholesterolemia	E78.00
Hypertrigylceridemia	E78.1
Hyperlipidemia, unspec.	E78.5
Lipid Disorders Screening	Z13.220
Palpitations	R00.2
PVD, unspec.	I70.9
Syncope and Collapse	R55

GLUCOSE/DIABETIC

Diabetes II, controlled	E11.9
Diabetes II, uncontrolled	E11.65
Diabetes Mellittus Screening	Z13.1
Impaired Fasting Glucose	R73.01
Insulin Resistance	E88.81
Prediabetes, Abnormal Glucose	R73.09

INFLAMMATION

Alcoholism	F10.20
Chills	R68.83
Chronic Fatigue Syndrome	R53.82
Fatigue	R53.83
Fever	R50.9
Gout, unspec.	M10.9
Insomnia	G47.00
Long-Term use of Medication	Z79.899
Malaise	R53.81
Myalgia	M79.1
Neuropathy, unspec.	G62.9
Personal Hx of Tobacco Use	Z87.891
Weakness	R53.1
Tobacco Use	Z72.0

METABOLIC

Cystitis, without Hematuria, unspec.	N30.90
Diarrhea	R19.7
Gastritis, unspec., without bleeding	K29.70
Gerd/Reflux	K21.9
Impaired Renal Function	N28.9
Kidney Stone	N20.0
Nausea with vomiting	R11.2
Urinary Frequency	R35.0
Vomiting	R11.10
Abnormal Gait	R26.9
Alzheimer's	G30.9
Altered Mental Status	R41.82
Dementia	F03.90
Lack of Coordination	R27.9
Memory Loss	R41.3
Mild Cognitive Impairment	G31.84
Osteoporosis, NOS	M81.0

Amenorrhea	N91.2
Dysmenorrhea	N94.6
Irregular Menses	N92.6
Infertility Female	N97.9
Vaginal Bleeding	N93.9
Vaginal Candidiasis	B37.3
Vulvovaginitis	N76.0

Alopecia	L65.9
Psoriasis, other	L40.8
Pruritus, NOS	L29.9

Abnormal Chest X-ray	R91.8
Chronic Bronchitis	J41.0
Cough	R05
Dyspnea	R06.00
Lung Disease, NOS	J98.4
Shortness of breath	R06.02
Sleep Apnea	G47.39

HEMATOLOGY

Abnormal Blood Chemistry	R79.89
Abnormal Blood Test, other	R78.89
Anemia, unspec.	D64.9
Folate-Deficiency	D52.9
Iron Deficiency	D50.9
Routine/Annual Health check-up	Z00.00
Routine/Annual Health check-up; w/ abnormal findings	Z00.01
Vitamin B12 Deficiencies	D51.9
Vitamin D Deficiencies	E55.9

Female Wellness

Hormone/Endocrine
Cortisol, DHEAs, Estradiol, TSH, Free T3, Free T4, FSH, LH, Testosterone, Progesterone, Prolactin, SHBG

Hematology
CBCw/Diff, Ferritin, Folate, Iron Profile, Vitamin B12, Vitamin D

Glucose/Diabetic
Average Glucose, Glucose, Hemoglobin A1c, Insulin

Metabolic
Calcium, Chloride, Potassium, Sodium, Phosphorus, Magnesium, Bicarbonate (CO2), BUN, Creatinine, eGFR, Anion Gap, AST, ALT, ALP, Albumin, Total Bilirubin, Total Protein, Amylase Uric Acid, GGT

Cardiovascular
LDL, Cholesterol, HDL, Triglycerides

Inflammation
CRP-HS

Male Wellness

Hormone/Endocrine
Cortisol, DHEAs, Estradiol, TSH, Free T3, Free T4, FSH, LH, Testosterone, Progesterone, Prolactin, SHBG, Free Testosterone, PSA Total, PSA Free

Hematology
CBCw/Diff, Ferritin, Folate, Iron Profile, Vitamin B12, Vitamin D

Glucose/Diabetic
Average Glucose, Glucose, Hemoglobin A1c, Insulin

Metabolic
Calcium, Chloride, Potassium, Sodium, Phosphorus, Magnesium, Bicarbonate (CO2), BUN, Creatinine, eGFR, Anion Gap, AST, ALT, ALP, Albumin, Total Bilirubin, Total Protein, Amylase Uric Acid, GGT

Cardiovascular
LDL, Cholesterol, HDL, Triglycerides

Inflammation
CRP-HS

Panel Tests

BMP

Na, K, Cl, CO2, GLUC, CREA, BUN, Ca

CMP

Na, K, Cl, CO2, GLUC, CREA, BUN, ALB, TP, Ca, ALP, ALT, AST, TBIL

ELECTROLYTES

Na, K, Cl, CO2

HEPATIC PANEL

ALP, ALT, AST, ALB, TBIL, DBIL, TP

LIPID PANEL

CHOL, HDL, LDL, TRIG, LDL(direct)

RENAL PANEL

Na, K, Cl, CO2, GLUC, CREA, BUN, ALB, PHOS, Ca

WRITE- IN CODES

PATIENT CONSENT AUTHORIZATION

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to River Town Diagnostics, its assigned affiliates and authorized representatives for laboratory services furnished to me by River Town Diagnostics. I irrevocably designate, authorize and appoint River Town Diagnostics or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to River Town Diagnostics immediately upon receipt. I hereby authorize River Town Diagnostics, its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to River Town Diagnostics, in compliance with federal and state laws. River Town Diagnostics, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of River Town Diagnostics and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

I hereby grant permission to River Town Diagnostics to obtain my sample for testing

Signature of Patient or Patient Representative/ Relationship to Patient

Date: