



Ward _____ Room _____
 HSN _____
 Chart # _____
 Patient Name _____
 Male Female
 D.O.B (dd/mm/yyyy) _____ Phone _____
 Address _____

RUH SCH SPH Other _____

LABORATORY MEDICINE

PHLEBOTOMY REQUISITION

Clinical Diagnosis: _____
 Requesting Physician: _____
 Additional Copies of Report to: 1. _____ 2. _____
 Collection (date & time): _____ (Print your Initials)
Priority: ROUTINE URGENT STAT TIMED (specify): _____ (hours)

<p>Check off Test Required</p> <p>CBC <input type="checkbox"/> CBC</p> <p>PT <input type="checkbox"/> PT (INR)</p> <p>APTT <input type="checkbox"/> PTT (APTT)</p> <p>FIB <input type="checkbox"/> Fibrinogen Level</p> <p>DDIM <input type="checkbox"/> D-Dimer</p>	<p>*These Test Require a 10 hr. Fast</p> <p>CK <input type="checkbox"/> CK – Total only</p> <p>CORT <input type="checkbox"/> Cortisol</p> <p>CREAT <input type="checkbox"/> Creatinine</p> <p>LYTE4 <input type="checkbox"/> Electrolytes (Na, K, Cl, CO₂)</p> <p>FER <input type="checkbox"/> Ferritin</p> <p>GGT <input type="checkbox"/> Gamma GT</p> <p>GLUFA <input type="checkbox"/> <u>Glucose – Fasting*</u></p> <p>GLUCR <input type="checkbox"/> Glucose – Random</p> <p>HMA1C <input type="checkbox"/> HbA1C</p> <p>IRONB <input type="checkbox"/> <u>Iron and TIBC*</u></p> <p>LITH <input type="checkbox"/> Lithium</p> <p>MG <input type="checkbox"/> Magnesium</p> <p>OSMO <input type="checkbox"/> Osmolality</p> <p>PHOS <input type="checkbox"/> Phosphate</p> <p>TP <input type="checkbox"/> Protein – Total</p> <p>PES <input type="checkbox"/> Protein Electrophoresis</p> <p>RHF <input type="checkbox"/> Rheumatoid Factor</p> <p>WASER <input type="checkbox"/> Syphilis Testing</p> <p>TRIG <input type="checkbox"/> Triglyceride</p> <p>THYSA <input type="checkbox"/> TSH</p> <p>TNTHS <input type="checkbox"/> Troponin T HS</p> <p>UREA <input type="checkbox"/> Urea</p> <p>URIC <input type="checkbox"/> Uric Acid</p>	<p>Aminoglycosides/TDM's</p> <p>Date of last dose: _____</p> <p>Time of last does: _____</p> <p>Dosage administered: _____</p> <p>CARBZ <input type="checkbox"/> Carbamazepine (Tegretol)</p> <p>CYCL <input type="checkbox"/> Cyclosporin (Pre)</p> <p>CY2 <input type="checkbox"/> Cyclosporin (Post)</p> <p>DIGI <input type="checkbox"/> Digoxin</p> <p>GENTC <input type="checkbox"/> Gentamicin</p> <p>PHENB <input type="checkbox"/> Phenobarbital</p> <p>PTNY <input type="checkbox"/> Phenytoin (Dilantin)</p> <p>SIRO <input type="checkbox"/> Sirolimus</p> <p>TACR <input type="checkbox"/> Tacrolimis</p> <p>TOBRM <input type="checkbox"/> Tobramycin</p> <p>VALPR <input type="checkbox"/> Valproic Acid (Epival)</p> <p>VANMC <input type="checkbox"/> Vancomycin</p> <p><i>✓one box only. For other Hepatitis markers, please order the 'other tests' section. New reactive results will trigger additional tests.</i></p> <p>HEPPA <input type="checkbox"/> Acute viral hepatitis undefined etiology (Hep A IgM, Hep B S Ag, Hep Bc IgM Ab, Hep C Ab)</p> <p>Chronic Viral Hepatitis:</p> <p>HBCHR <input type="checkbox"/> Hepatitis B (Hep B S Ab, Hep B S Ag, Hep Bc Tot Ab)</p> <p>HCAB <input type="checkbox"/> Hepatitis C (Hep C Ab)</p> <p>Hepatitis Immune Status:</p> <p>HAABT <input type="checkbox"/> Hepatitis A (Hep A Total Ab)</p> <p>HBABS <input type="checkbox"/> Hepatitis B (Hep B S Ab)</p> <p>CMVA <input type="checkbox"/> Acute CMV (CMV IgM)</p> <p>CMVI <input type="checkbox"/> Chronic or Past Exposure to CMV (CMV IgG)</p>
---	---	--

Other Tests (specify): _____
