

Date }

ACCOUNT INFORMATION

NAME
ADDRESS
CITY STATE ZIP
PHONE

Department of Laboratories
St. Louis, Missouri 63110
(314) 454-2708



HOSPITAL • ST. LOUIS
BHC HealthCare

PATIENT INFORMATION

PATIENT LAST NAME OR ID# FIRST DOB SEX
ADDRESS SSN
CITY STATE ZIP PHONE
DIAGNOSIS/SIGNS/SYMPOM IN ICD9 FORMAT } REFERENCE NO. } RACE }

ORDERING PHYSICIAN

SECOND REPORT TO

BILLING INFORMATION } BILL TO: ACCOUNT PATIENT INSURANCE RESEARCH ACCT.

ACCOUNT PATIENT ACCT. RESEARCH ACCT.

Medicare (must include Alpha Code) Medicaid CARE PARTNERS PARTNERS HMO
ID # ALPHA Code GHP OTHER

TESTING INFORMATION

STAT CALL RESULTS TO: _____ COMPLETE AND
(# _____) ATTACH STAT FLYER

INSURANCE CO. I.D. #

COLLECTION INFORMATION:
DATE _____ TIME _____ INITIALS _____

ADDRESS GRP. #

INSURED NAME (IF NOT PATIENT) PLAN NAME

MUST HAVE COLLECTION DATE AND TIME

PARENT OR GUARDIAN

GUARANTOR

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits.

- Tests Requested: Quantitative Phenylalanine (Serum PKU)
 Cyclosporine
 Tacrolimus (FK506)
 Other _____

Instructions:

1. Write first and last name of patient and date of birth on each tube of blood.
2. Mark test requested
3. Wrap tube of blood in absorbent material and place in enclosed ziplock bag. Place plastic bag in styrofoam container. Tape together.
4. The hospital must have a name, date of birth, physician and the date specimen was collected in order to proceed with testing. Place taped styrofoam container and form in box. Tape box closed. Mail immediately.
5. All specimens must be labeled and accompanied by a Patient Information Form. These forms can be obtained through the patient's medical division or through the St. Louis Children's Hospital Clinical Laboratories at (314) 454-4161.

If your insurance coverage has changed since your last test was sent & performed at SLCH or you have not been a registered patient at St. Louis Children's Hospital before, please submit all pertinent insurance information in the box provided above. Please send it with this specimen.

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