

CLIENT NAME AND ADDRESS:

DOCTOR: _____



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PATIENT INFORMATION

LAST NAME:		FIRST NAME:				MIDDLE INITIAL:		
ADDRESS:					CITY:	COUNTY:	STATE:	ZIP:
DATE OF BIRTH:	AGE:	SEX:	SOCIAL SECURITY NUMBER:	HOME PHONE NUMBER:	WORK PHONE NUMBER:			

ICD DX CODES		INSURANCE INFORMATION										
		<input type="checkbox"/> PATIENT		<input type="checkbox"/> INSURANCE		<input type="checkbox"/> PHYSICIAN ACCOUNT		<input type="checkbox"/> MEDICARE		<input type="checkbox"/> MEDICAID		STATE:
		INSURED'S NAME (IF DIFFERENT FROM PATIENT):				INSURED'S SOC. SEC. NO.:		PATIENT RELATIONSHIP TO INSURED				
		MEDICARE I.D. NUMBER:				MEDICAID I.D. NUMBER (INCL. SUFFIX):		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT HIV TESTING The following must be provided. - I provided pre-test counseling in accordance with Article 27-F of the N.Y. Public Health Law. Questions about the test were answered for the individual whose informed consent was obtained. A copy of this form was offered to him/her.				
		PRIMARY INSURANCE NAME AND PLAN:				EMPLOYER / GROUP NAME:		_____ Authorized Signature Required				
		POLICY I.D. NUMBER:				GROUP:						
		ORDERING PHYSICIAN'S SIGNATURE: (required for medicaid)										

DATE COLLECTED:	TIME COLLECTED:	<input type="checkbox"/> NON FASTING <input type="checkbox"/> FASTING <input type="checkbox"/> STAT		
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LIPID PROFILE		BASIC METABOLIC		COMPREHENSIVE METABOLIC		HEPATIC FUNCTION		NOTES	
LIPID PROFILE		BASIC METABOLIC		COMPREHENSIVE METABOLIC		HEPATIC FUNCTION			
Albumin	S	Potassium	S	T4, Free	S	Rheumatoid Factor	S	Dilantin/Phenytoin	S
Alkaline Phosph.	S	Protein, Total	S	TSH	S	RPR	S	Lead	L
ALT (SGPT)	S	Sodium	S	Testosterone	S	Rubella Ab	S	Valproic Acid	S
AST (SGOT)	S	Triglycerides	S	IMMUNOLOGY		Thyroglobulin	S	TUMOR MARKERS	
Amylase	S	Troponin I	S	Allergens, Eastern	S	Thyroid Microsomal	S	AFP	S
Bilirubin, Direct	S	Uric Acid	S	Allergens, Food	S	Toxoplasmosis	S	CA 15-3	S
Bilirubin, Total	S	Vitamin B12	S	ANA	S	Varicella Ab	S	CA 27-29	S
BNP	L	HEMATOLOGY		DNA, DS Ab	S	MICROBIOLOGY		CA 125	S
BUN	S	CBC /w Differential	L	ASO	S	Chlamydia, DNA	SW	CEA	S
Calcium	S	ESR	L	CMV IGG AB	S	Gonorrhoeae, DNA	SW	Pros. Acid. Phos.	S
Chloride	S	HGB Electroph.	L	CRP Inflammation	S	Occult Blood Stool	ST	PSA, Total	S
Cholesterol	S	PT/INR	BL	CRP Ultrasens	S	Ova & Parasites	ST	PSA, Free & Total	S
CO2	S	PTT	BL	C3-Complement	S	Fungal Culture	O	Biopsy _____	
Creatinine Kinase	S	Reticulocyte Count	L	C4-Complement	S	Genital Culture & S	SW	Tissue/Source _____	
Creatinine	S	Sickle Screen	L	Epstein Barr Virus	S	Stool Culture & S	ST	ICD/Dx _____	
Ferritin	S	ENDOCRINOLOGY		Hepatitis A Ab	S	Throat Culture & S	SW	<input type="checkbox"/> Thin Prep <input type="checkbox"/> Sure Path <input type="checkbox"/> PAP: <input type="checkbox"/> Cerv <input type="checkbox"/> Vag. <input type="checkbox"/> Endoc. LMP: _____ Pregnt. Wks: _____	
Folic Acid	S	Beta hCG	S	Hepatitis B Core Ab	S	Urine Culture & S	U	<input type="checkbox"/> Postmeno <input type="checkbox"/> PP <input type="checkbox"/> IUD <input type="checkbox"/> HPV High Risk <input type="checkbox"/> HPV Low Risk <input type="checkbox"/> Hormone Rx GYN HISTORY:	
GFR, Estimated	S	Cortisol	S	Hepatitis B Surf Ab	S	Wound Culture & S	SW	<input type="checkbox"/> Abn. PAP _____ <input type="checkbox"/> Abn. Bleeding _____ <input type="checkbox"/> Hx Malignancy _____	
Globulin	S	DHEA-Sulfate	S	Hepatitis B Surf Ag	S	Misc. Culture	O		
Glucose	G	Estradiol	S	Hepatitis C Ab	S	BLOOD BANK			
Glucose ___ Hrs P.P.	G	FSH	S	HIV 1,2 Screening	S	Antibody Screen	PK		
GGT	S	Growth Hormone	S	Herpes 1,2	S	Blood Group & Rh	PK		
Hemoglobin A1C	L	Insulin	S	Helico. Pylori Ab	S	URINE			
Homocysteine	S	LH	S	IgA	S	Creat. Clearance	U S		
Iron, Total	S	PTH, Intact	S	IgG	S	Drugs of Abuse	U		
Iron & TIBC	S	Progesterone	S	IgM	S	Microalbumin	U		
LDH	S	Prolactin	S	IgE	S	Pregnancy	U		
Lipase	S	T4, Total	S	Lyme Ab	S	Urinalysis	U		
Magnesium	S	T3, Uptake	S	Measles Ab	S	TOXICOLOGY			
Phosphorus	S	T3, Total	S	Mono (Heterophil)	S	Carbamaz/Tegretol	S		
		T3, Free	S	Mumps Ab	S	Digoxin	S		

CUSTOM PROFILES AND ADDITIONAL TESTS ALL INFORMATION MUST BE PROVIDED

Spun Barrier Top
 Lavender Top
 Blue Top
 Gray Top
 Red Top
 Other
 Thinprep
 Sure Path
 Urine
 SW Swab