



Patient Name: _____
 MR #: _____
 CSN#: _____
 DOB: dd-mmm-yyyy Age: _____ Sex: _____
 Date/time: dd-mmm-yyyy

VCH Downtime Lab and Ancillary Dept Requisition

Not Part of Medical Record - Do Not Scan

Diagnostic Laboratory 4605 TVC, Nashville, TN 37232

Month:	Day:	Year:	Collection Time: a.m. p.m.	Ordering Dept./Service:	Collection Location:	Allergies:
Ordering Physician:			Physician Beeper/Phone:	Height:	Weight:	Unit/Bed: <input type="checkbox"/> STAT LAB

MAIN LAB (Multiple Lab Tests Can Be Ordered) (Tubes: 109, 606, 801) ICD 10 CODE:

#	Lab Code	Chemistry	Tube Color	#	Lab Code	Chemistry	Tube Color	#	Lab Code	Hematology	Tube Color	#	Lab Code	Body Fluids	Tube Color
	ABL	Albumin	LGN		LDH	LDH, Blood	LGN		CBP	CBC/Platelets	LV		CSF	CSF Cell Count (Body Fluid Container)	
	AMY	Amylase	LGN		MG	Magnesium	LGN		CPD	CBC/Platelets/ Diff	LV		SFG	CSF, Glucose (Sterile Plastic LP Tube)	
	BMP	Basic Metabolic Panel (Elec, Glu, Bun, Crea, CA)	LGN		OSM	Osmolality	LGN		HCT	Hematocrit	LV		SFP	CSF, Protein (Sterile Plastic LP Tube)	
	BHC	Beta HCG, Serum	LGN		PO4	Phosphorus, Inorganic	LGN		PLT	Platelets	LV		UCG	Pregnancy Test, Urine	UR
	TBR	Bilirubin, Total	LGN		K	Potassium	LGN	#	Lab Code	Coagulation	Tube Color		UA1	Urinalysis	UR
	CA	Calcium	LGN		PRO	Protein Total, Blood	LGN		DDI	D-Dimer for DIC, Quant	LB		OSU	Urine Osmolality (ARUP # 0020228)	UR
	CO2	Carbon Dioxide	LGN		ALT	SGOT	LGN		FBG	Fibrinogen	LB				
	CL	Chloride	LGN		NA	Sodium	LGN		PT	Prothrombin Time	LB	#	Lab Code	Other	Tube Color
	CHL	Cholesterol	LGN		TGL	Triglycerides	LGN		PTT	Partial Thromboplastin Time	LB		ABG	Blood Gas, Arterial	
	CK-MB	CK-MB CK Ratio	LGN		TRI	Troponin I	LGN	#	Lab Code	Toxicology	Tube Color		VBG	Blood Gas, Venous	
	CMP	Comp Metabolic Panel (BMP, TBIL, Alk Phos, PRO, AST, ALT)	LGN		UAB	Uric Acid	LGN		DIG	Digoxin Date/time last dose:	DGN		CAI	Ionized Calcium	Full Dark Green
	CRE	Creatinine	LGN			Other:			DSA	Drug Profile (U)	UR			Other:	
	GLU	Glucose	LGN			Other:			PYT	Phenytoin (Dilantin) Date/time last dose:	DGN			Other:	

Ancillary Departments: One (1) department/product per form

Requested Order/s: _____

Reason/History/Diagnosis/ICD 10 Code _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Peds Nutrition (Phone 3-9763 Fax 3-8810) | <input type="checkbox"/> Peds Respiratory (Phone 715-9014 Fax 6-4351) | <input type="checkbox"/> Peds Radiology Phone: 6-7155, Fax: 3-1841 |
| <input type="checkbox"/> *Non-MD Consult _____ | <input type="checkbox"/> Peds Echo (Phone 6-2481, Fax 3-1432) | <input type="checkbox"/> Social Work (beep SW) |
| <input type="checkbox"/> Miscellaneous _____ | <input type="checkbox"/> Peds Pulmonary Function (Phone 6-2556, Fax 6-3665) | <input type="checkbox"/> Peds EKG (paper 835-1980) |

Other: _____

Collector's Print Name:	Collector's Signature:	Collection Date/Time:	Collector's Vunet ID
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