

## LAB REQUEST FORM

**LABEL – LAB ONLY**

**Express Medical Experts**  
 2020 Kingsley Avenue Suite 2B  
 Orange Park, FL 32073.  
 Phone: 904-647-8177  
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 CLIA# 10D2219475

### PRACTICE INFORMATION

Facility/Clinic Name:	Ordering Physician:	NPI#
Address:	City:	State: Zip Code:
<b>PATIENT INFORMATION:</b> Please attach medication list & patient demographic sheet or complete the following section.		
First Name:	Last Name:	DOB:(MM/DD/YYYY) Sex: <u>  </u> F <u>  </u> M
Phone Number:	DOI (If applicable)	Email:
Address	City	State Zip Code
Race: <u>  </u> American Indian/Alaska <u>  </u> Black/African American <u>  </u> Multi Race <u>  </u> White <u>  </u> Hawaiian <u>  </u> Asian		
<b>BILLING INFORMATION:</b> Please attach patient demographic sheet or complete the following section. <u>  </u> Medicare <u>  </u> Tricare <u>  </u> Commercial		
Insurance Company:	Member ID:	Group Number:
<u>  </u> SELF-PAY	Method of Payment (check one):	<input type="checkbox"/> American Express <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Other

### TESTING INFORMATION

<b>SPECIMEN COLLECTION:</b>  Date Collected: _____  Time: _____ Collector Initials: _____  <b>SEROLOGY/VIROLOGY</b>  <input type="checkbox"/> RPR W/ REFLX <input type="checkbox"/> HEPATITIS B SURFACE ab <input type="checkbox"/> RUBELLA <input type="checkbox"/> MUMPS <input type="checkbox"/> VARICELLA ZOSTER <input type="checkbox"/> MEASLES <input type="checkbox"/> CHLAMYDIA/GONNORRHEA (URINE)  <input type="checkbox"/> IMMIGRATION PANEL (Includes all tests listed in this form)	<input type="checkbox"/> QuantiFERON - TB Gold  SPECIMEN INCUBATED? <u>  </u> YES <u>  </u> NO  START TIME: _____ TEMP: _____ DATE: _____ BY: _____  END TIME: _____ TEMP: _____ DATE: _____ BY: _____  Optimal Collection Time / Storage / Transportation Receipt of Samples
<b>All specimens that DO NOT MEET the collection/transport requirements will be REJECTED.</b>	
Blood Collection Tube: 6mL Lithium - heparin tube (green top/white label). <ul style="list-style-type: none"> <li>• Tubes should be at room temperature (17–25°C) at the time of blood filling.</li> <li>• Only a Lithium - heparin anticoagulant is acceptable.</li> </ul> <b>Blood collection:</b> Collect a minimum volume of 5 mL of blood into a single Lithium - heparin tube. <ul style="list-style-type: none"> <li>• Gently mix by inverting several times to dissolve the heparin.</li> <li>• Blood must first be held at room temperature (17–25°C) for a minimum of 15 minutes and a maximum of 3 hours before being placed in the refrigerator (2–8°C).</li> <li>• Specimen may be held in the refrigerator for 6–8 hours before shipping.</li> </ul> <b>Shipping to Express Medical Experts:</b> <ul style="list-style-type: none"> <li>• Ship on ice packs.</li> <li>• Total time from collection to receipt EME laboratory cannot exceed 12 hours.</li> </ul> <b>Specimen Shipping &amp; Receipt / Handling at EME:</b> <ul style="list-style-type: none"> <li>• Specimens should be shipped Monday to Friday and received at EME by 4pm.</li> </ul>	
TOTAL NUMBER OF TUBES  HEPARIN TUBE _____ SST _____  URINE TUBE (NO ADDITIVES) _____	

Ordering Physician (Print)

Signature

Date

The provider certifies that the requested tests are medically necessary, that the medical necessity of requested tests is documented in the patient's chart, and the need for the requested tests has been explained to the patient.