

LABORATORY ORDER

**LAB HOURS: MONDAY – FRIDAY
7:00 AM – 7:00 PM**

DIAGNOSIS: _____
MEDICALLY NECESSARY TO SUPPORT TESTING

PLEASE OBTAIN THE LAB TEST(S) MARKED BELOW:

- ALT AST
- COMPREHENSIVE METABOLIC PANEL (**CMP**)
- BASIC METABOLIC PROFILE (**BMP**)
- CBC WITH PLATELETS (**CBC**)
- GLUCOSE (**GLU**) HEMOGLOBIN A1C (**GHB**)
- FASTING** LIPID PROFILE
- THYROXINE AND T3 RESIN UPTAKE (**FTI**)
- TSH TOTAL T3 (**T3T**)
- ANTI-THYROID MICROSOMAL ANTIBODIES (**THYMAB**)
- FREE T4 BY EQUILIBRIUM DIALYSIS (**PLEASE ORDER UNDER MISCELLANEOUS**)
- GLYCOHEMOGLOBIN (**TGHB**) NOT HGBA1C
- FRUCTOSAMINE (**GLYCAPR**)
- 25-HYDROXYVITAMIN D (**VITD25**)
- VITAMIN B12 (**B12**)
- SPOT URINE FOR MICROALBUMIN / CREATININE RATIO (**UMALBQL**)

PHYSICIAN OR NURSE PRACTITIONER SIGNATURE: _____
(DANIEL WEISS MD OR PAMELA COMBS RN, MSN, BC-ANP, CDE)

PLEASE OBTAIN LAB TESTS 1 WEEK BEFORE NEXT OFFICE VISIT IN _____

WITH _____

ADDITIONAL COPIES TO: _____
(PLEASE PROVIDE PHYSICIAN’S FULL NAME AND OFFICE NUMBER)

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JOSLIN DIABETES CENTER AFFILIATE at St. Vincent Charity Hospital
Phone: 216-363-3301 Fax: 216-363-3304



ST. VINCENT CHARITY
MEDICAL CENTER

2351 EAST 22ND STREET
CLEVELAND, OH 44115
stvincentcharity.com

A Ministry of the Sisters of Charity Health System

PATIENT LABEL



MR.ORDER