Wellness Blood Req Form
999 Chestnut St SE, Gainesville, GA 30506
Office 844.794.3637 Fax 678.392.2483 Pro-Genex.com

Collection Date:_____________ Collection Time___________ DIAG/ICD 10 code(s):____________________

Patient Name First: _________________________ Last ___________________________ MI: ______

DOB: ______________________ Gender: ☐ Male or ☐ Female

Please submit a patient Face Sheet or Demographics Sheet OR the following information must be completed. Lab specimens will be held and not tested until the information in this section is received.

BILL TO: INSURANCE | PATIENT | MEDICARE | MEDICAID | Facility/Provider ordering the test
INSURANCE COMPANY:________________________________POLICY: ____________________________

GROUP#:____

Relationship to Patient:____
First MI Last

Patient Address:____
Street City State Zip

Patient Phone Number:____

CHEMISTRY TEST **(**Serum Separator Tube – Gold or Tiger Top**)**

Acute Hepatitis Profile **LAB551**

Comprehensive Metabolic Panel **LAB17**

TSH **LAB129**

Iron/IBC **LAB829**

Ammonia **LAB47**

RPR **LAB494**

HIV **LAB473**

Magnesium **LAB103**

Ferritin **LAB68**

Lithium **LAB29**

Vit D **LAB535**

Folate **LAB69**

Vit B12 **LAB67**

Depakote **LAB2825**

OTHER: ___________________________________

OTHER: ___________________________________

LAVENDER TOP (EDTA)

CBC with Diff **LAB1748**

Hgb A1C **LAB90**

Sed Rate **LAB322**

URINE **(**sterile cup**)**

Urinalysis **LAB347**

Urine Culture **LAB239**

Urinalysis with Reflex to Culture **LAB9967**

Chlam/Gon **LAB1376**

TESTOSTERONE **LAB124**

*OTHER***:** ________________

ADD ON TEST options:

☐ Hepatitis C Virus (HCV) by Quantitative NAAT with HCV Genotype if indicated **LAB123000576**
(PG must fax this add on to 770-219-4892)

☐ HIV-1,2 AB, Diff, Supplemental w/Reflex **LAB1270**

*OTHER***:** ___________________________________ *OTHER:* ___________________________________

By submitting this requisition form and corresponding specimen for testing at Pro-GeneX Laboratories, Inc., I acknowledge as the ordering provider, that the test(s) requested on this form are medically necessary and reasonable for the diagnosis and treatments rendered; and I have written an order and documented medical necessity in the patient's medical record that supports the need for the requested test(s).