BASSETT HEALTHCARE NETWORK
OBSTETRICS
LAB REQUEST FORM #10
5835 12/12/07,1/14/08,10/6/08,1/9/09,4/6/09,7/6/09,1/4/10,2/10/10
7/19/10,10/4/2010,1/3/11,4/4/11, 4/14/14,10/6/14, 1/5/15
5/15/15,8/10/15,9/7/23 (f\lab\.doc)

Date of Request _____   Visit Number: _____

Chart # _____   Location: _____

Name Last: _____   First: _____

Date of Birth _____

* 5 8 3 5 *

Ordering Provider: _____

Attending Provider: _____

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

Diagnosis Code:
or
Descriptive Diagnosis:

BRING TO LAB ON T2

*** DO NOT USE THIS AS AN ORDER UNLESS FOR DOWNTIME – RELEASE ORDERS FROM EPIC***

28 WEEK WORKUP
Please circle requests below
NURSE INFORMATION:

Fasting Glucose Screen: _____mg/dl   _____ time/date   Initials: _____

Glucola Administered: _____vol   _____ time/date   Initials: _____

GLUCOSE TOLERANCE TESTS FOR PREGNANT OR POSTPARTUM WOMEN

Select Test	LIS Code	Glucose Testing Performed	Usage
Pregnant or Postpartum Women			
	LAB3583*	1 hr draw post Glucola	Screen (50 G) used AS Gestational Diabetes Challenge
	LAB3000	Fasting, 1, 2 hr glucoses	Standard OGTT (75g). Used for gestational
	LAB169*	Fasting and 2 hr glucose	Standard OGTT (75g). Used 6 weeks postpartum.
	LAB3545	Fasting, 1 hr, 2 hr, 3 hr glucose	Follow-up testing from failed 1 GCT (100g).

RHOGAM ORDERS (INCLUDES TSC)

Code   **Test Name**

LAB21075   Antepartum Rhogam

Check One:

☐   Micro Dose (12 weeks gestation or less)

☐   Full Dose

Rhogam Needed:
Date: _____
Time: _____
Location: _____

REQUISITIONS Lab

Provider's Signature: _____

Signed Date and Time: _____

Received by: _____