Date of Request Requisition #

Date of Birth

Name Last: First:

Employee Health Facility

* 1 0 3 8 5 *

Ordering Provider:

Attending Provider:

BASSETT HEALTHCARE NETWORK

Employee Health Testing
Pre-Employment/ Annual

#10385 8/18,4/21/20,10/1/21,3/20/23,5/1/23,6/14/23,9/19/2023,10/23

Please circle requests below.

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

Diagnosis Code:
or
Descriptive Diagnosis:

ENTER USING REQUISITION ENTRY USING APPROPRIATE SUBMITTER RECORD BASED ON LOCATION EMPLOYED

Pre-Employment

Code	Test Name
LAB471	Hep B Surface AG
LAB472	Hep B Surface AB
LAB657	Measles IgG
LAB160	Mumps IgG
LAB496	Rubella AB
LAB162	Varicella IgG
LAB3110	Quant Gold

Other Testing:

Annual

Code	Test Name
LAB140	BUN
LAB66	CRTN
LAB1748	CBCA
LAB20	Hepatic Function Panel
LAB50	TBIL

Other Testing:

Provider's Signature:

Signed Date and Time:

Received by:

REQUISITIONS Lab