

THE NATIONAL WOMEN'S HORMONE LABORATORY

DRAW AND SEND SPECIMEN TO:

6901 Mercy Rd. Omaha Ne 68106
Phone: 402-390-0532 Fax: 402-505-8931
CLIA # 28D043756

STANDING ORDER

DATE OF ISSUE: _____

DATE OF EXPIRATION: _____

Thomas W. Hilgers M.D. Medical Director
Thomas W. Hilgers M.D. Laboratory Director

PATIENT INFORMATION

Name (Last, First) _____ Date of Birth ___/___/_____

Address _____ Phone ___-___-_____ Gender MALE / FEMALE

PPVI Account # _____ *****NEW PATIENTS MUST SEND DEMOGRAPHIC INFORMATION FOR PROCESSING*****

BILLING INFORMATION

Bill To: Patient Self-Pay / Insurance* / Client *SEND COPY OF INSURANCE CARD (front and back)

Insurance _____ Ordering Provider _____

Subscriber ID _____ Group # _____ Provider Phone # ___-___-_____ Fax # ___-___-_____

Name of Policy Holder _____ Signature of Provider (Required) _____

ORDER INFORMATION

Patient on HCG: Y/N

Last Menstrual Period ___-___-_____ Cycle Day ___ or Peak + _____

OB ETA ___-___-_____ by: US LMP PEAK DAY
Gestational Weeks _____ Days _____

DATE DRAWN _____ TIME DRAWN _____ INITIALS _____ Facility _____ Phone ___-___-_____

- | | | | |
|---|---|------------------------------------|--|
| <input type="checkbox"/> 84144 PROGESTERONE | <input type="checkbox"/> 82157 ANDROSTENEDIONE | <input type="checkbox"/> 84443 TSH | <input type="checkbox"/> 83001 FSH |
| <input type="checkbox"/> 82670 ESTRADIOL | <input type="checkbox"/> 82627 DHEA-SO4 | <input type="checkbox"/> 84439 FT4 | <input type="checkbox"/> 83002 LH |
| | <input type="checkbox"/> 84270 SHBG | <input type="checkbox"/> 84480 T3 | <input type="checkbox"/> 84146 PROLACTIN |
| | <input type="checkbox"/> 84403 TOTAL TESTOSTERONE | <input type="checkbox"/> 84436 T4 | |
| <input type="checkbox"/> 84702 HCG Quantitative | | | |

DRAWING INSTRUCTIONS

Draw blood into a red top tube or SST/Tiger Top

Let specimen clot and spin for 15 minutes (or follow your labs procedure for collecting serum)

Submit a minimum of 2 mL serum in an aliquot tube. Label with the patients NAME/DOB/DATE. ****DO NOT SEND IN SST****

Progesterone, Estradiol and HCG may be room temperature for < 5days, ALL other tests must be sent on ICE PACKS for next day delivery

Prepaid shipping kits are available for purchase, please call 402-390-0532 to order a kit

DIAGNOSIS

Diagnosis is MANDATORY for all Patient and Insurance Billing. Please circle the appropriate Diagnosis.

- | | | |
|------------------------------------|---|---------------------------------------|
| N93.9 Abnormal Uterine Bleeding | N92.5 Irregular Menstruation, Other | Z32.00 Pregnancy Test, Result unknown |
| N91.2 Amenorrhea | E34.9 Low Progesterone | N94.3 Premenstrual Tension Syndrome |
| E28.8 Hyperhormonal | E28.9 Luteal Phase Defect | E03.9 Hypothyroidism, NOS |
| N91.0 Primary | E28.8 Late Luteal Defect | E05.90 Hyperthyroidism, Unspecified |
| N91.1 Secondary | N91.1 Metrorrhagia | Z13.29 Thyroid Disorder Screening |
| N91.0 Anovulation | N92.4 Menopausal | R53.83 Fatigue, Other |
| E23.6 Anterior Pituitary Disorders | O72.1 Postpartum | N80.9 Endometriosis, Unspecified |
| N94.6 Dysmenorrhea | N92.4 Premenopausal | N71.1 Endometritis, Chronic |
| N94.4 Primary | F45.8 Psychogenic | E28.39 Other Primary Ovarian Failure |
| F45.8 Psychogenic | E28.2 Polycystic Ovaries | Other Diagnosis _____ |
| N94.5 Secondary | Z34.90 Pregnancy, Normal # Wks _____ | |
| N96 Habitual SAB (Hx of) | O09.891 Pregnancy High Risk # Wks _____ | |

