



**DEPARTMENT OF RADIOLOGY/LAB LABORATORY REFERRAL FORM**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Patient Address \_\_\_\_\_  
 Patient Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Gender  Female  
 Diagnosis \_\_\_\_\_  Male  
 Insurance \_\_\_\_\_  
 Insurance ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Address \_\_\_\_\_

Note: Laboratory Services by Appointment Only

Tel: 636-230-1833 or 636-227-2100 ext. 1833

Fax: 636-207-2429

**LABORATORY**

In House Lab Tests/Exams Most Results Same Day	Tests Sent Out to Reference Lab More Lab Tests Available - Call 636-230-1833 Most Results 24-48 Hours		
<input type="checkbox"/> Body Composition <input type="checkbox"/> CBC <input type="checkbox"/> EKG 12-Lead <input type="checkbox"/> ESR <input type="checkbox"/> Mono <input type="checkbox"/> Pregnancy (Urine) <input type="checkbox"/> Quick Strep <input type="checkbox"/> RA <input type="checkbox"/> Spirometry <input type="checkbox"/> Urinalysis	<b>Special Panels Not Billable to Insurance Most Results 24-48 Hours</b>	<input type="checkbox"/> Amylase <input type="checkbox"/> Arthritis Profile Par 5 <input type="checkbox"/> Arthritis Profile Par 7 <input type="checkbox"/> Blood Group RHO <input type="checkbox"/> Basic Metabolic Panel <input type="checkbox"/> CA-125 <input type="checkbox"/> CA 15 <input type="checkbox"/> Cardiac Profile <input type="checkbox"/> Comp Metabolic Panel <input type="checkbox"/> C-Reactive Protein <input type="checkbox"/> CRP High Sensitivity <input type="checkbox"/> Estrogens Total/Serum <input type="checkbox"/> Estrogens, Fractional <input type="checkbox"/> Ferritin <input type="checkbox"/> Folate	
	<b>Cultures Most Results 48+ Hours</b>	<input type="checkbox"/> Glucose Serum <input type="checkbox"/> Glycohemoglobin <input type="checkbox"/> Insulin <input type="checkbox"/> Iron <input type="checkbox"/> Lipid Panel (AMA) <input type="checkbox"/> Progesterone <input type="checkbox"/> PSA <input type="checkbox"/> SGOT <input type="checkbox"/> SGPT <input type="checkbox"/> Testosterone Serum <input type="checkbox"/> TSH <input type="checkbox"/> Thyroid Antibody <input type="checkbox"/> Vitamin D <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> Vitamin B6	
	<input type="checkbox"/> Chem Panel (Small) <input type="checkbox"/> Chem Panel (Large) <input type="checkbox"/> Hypothyroid Screen	<input type="checkbox"/> Fungus Culture <input type="checkbox"/> Sputum Culture <input type="checkbox"/> Stool Culture <input type="checkbox"/> Urine Culture	
	<input type="checkbox"/> Other _____ _____ _____		

Referring Doctor \_\_\_\_\_  
 Referring Doctor Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Billing  Bill Patient  Bill Referring Doctor

Suite \_\_\_\_\_  
 e-mail \_\_\_\_\_  
 Fax \_\_\_\_\_  
 License Number \_\_\_\_\_  
 NPI \_\_\_\_\_

Doctor's  
Signature \_\_\_\_\_

Date \_\_\_\_\_