Western Maryland Health System
12500 Willowbrook Rd, SE, Cumberland, MD 21502
Phone: 240-964-2522 Fax: 240-964-2525

PREADMISSION TESTING

Collected By

Date Collected

Time Collected

PATIENT NAME	LAST	FIRST	M.I.	REQUESTING PHYSICIAN (Please Print)

SEX	RACE	BIRTH DATE : MO/ DAY/YR	SOCIAL SECURITY NUMBER (LAST 4 DIGITS) xxx-xx-	REQUESTING PHYSICIAN SIGNATURE and DATE

BILLING INFORMATION: BILL TO: CLIENT , PATIENT - (COMPLETE SECTION A) , INSURANCE - (COMPLETE SECTION B and C)

Section A	STREET ADDRESS CITY STATE ZIP		TELEPHONE NO.

Primary Insurance Section B	NAME OF INSURANCE COMPANY		Secondary Insurance Section C	NAME OF INSURANCE COMPANY	
	INSURANCE NO-POLICY	GROUP		INSURANCE NO-POLICY	GROUP

PHYSICIAN DIAGNOSIS REQUIREMENT NOTICE	When ordering tests, please be informed that the physician (or other authorized individual) is required to make an independent medical necessity decision with regard to each test the laboratory will bill. Additionally, the physician (or other authorized individual) understands he or she is required to submit narrative diagnosis information, supported by the patient's medical record. When medical necessity requirements are not met, an ABN must be completed to inform the patient they may be responsible for payment. Obtain a signed ABN for tests with defined frequency limits. NARRATIVE DIAGNOSIS or SYMPTOM :

	CBC/Autodiff - If flag, Man Diff at no charge	85025
	GLUCOSE	82947
	LYTES	80051
	BUN	84520
	CREATININE	82565
	BMP (Basic Metabolic Panel)	80048
	CMP (Comprehensive Metabolic Panel)	80053
	CHECK-TYPE (No charge ABO/Rh) **Order only if patient needs Type/Screen or Type/Xmatch. (Must be drawn PRIOR to TS/TX).**	
	TYPE & SCREEN * 86900,86901,86850 **DATE OF SURGERY**: _____ **NOTE: Also order Check-Type above.**	
	TYPE & CROSS* 86900,86901,86920 # OF UNITS: _____ **DATE OF SURGERY:** _____ **NOTE: Also order Check-Type above.**	
	PLT (Leuko-reduced plat pheresis) # OF UNITS _____	

	PT (Prothrombin)	85610
	APTT	85730
	BLEEDING TIME	85002
	HCG QUALITATIVE	84703
	UA Routine – Automated w/Microscopy	81001
	UA Automated Dipstick w/out Microscopy	81003
	UA Microscopic only	81015
	HIV 1, 2 Antibody. If Reactive, confirmation performed at additional charge. 86703 _____PATIENT COUNSELED **(Requirement)**	

Instructions for Type & Screen or Type & Crossmatch:

If the patient **has not** been pregnant or transfused in the previous 3 months, Type & Screen or Type & Crossmatch may be drawn 2-3 days prior to surgery. Maximum is 3 days.

If the patient **has been** transfused/pregnant in the previous 3 months, Type & Screen or Type & Crossmatch must be drawn the day before surgery.

Preadmission Requisition-2
Master Req 3/22/01
DATE OF REVISION: 3/1/09
FORM # 0027638