Dignity Health
HealthCare Clinical Laboratory

CUSTOMER SERVICE: (209) 467–6430

TOLL FREE: 1-888-LAB-HCCL

FOR LAB USE ONLY

Place Label Here

CLIENT#

FAX:
PHONE:

☐ **STAT** ☐ FASTING

LAB MEDICAL DIRECTOR: STEPHEN G. CONNOLLY, M.D

SEND REPORT BY: ☐ FAX:_____ ☐ CALL:_____	**DATE COLLECTED**	**TIME COLLECTED**	**COLLECTED BY**
PATIENT'S LAST NAME / **FIRST** / **MIDDLE INITIAL**	**PATIENT'S RACE** ☐ American Indian/Alaska Native ☐ Black/African ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ White ☐ Other		**PATIENT'S ETHNICITY** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
SEX ☐ M ☐ F / **DATE OF BIRTH** / **PATIENT PHONE#**	**INSURANCE:** **Please attach copy of insurance card (front and back)**		
RESPONSIBLE PARTY (PRINT NAME)	**BILL TO:** ☐ CLIENT ☐ PATIENT ☐ INSURANCE ☐ MEDI-CAL ☐ MEDICARE ☐ WORKMAN'S COMP	**MEDI-CAL #**	
RELATION ☐ Self ☐ Spouse ☐ Child ☐ Other_____		**MEDICARE#**	
BILLING ADDRESS / **APT.#**		**PATIENT ACKNOWLEDGEMENT OF RESPONSIBILITY** **All Patients**: I agree that Laboratory will furnish to my designated insurance carrier the information on this form necessary for reimbursement. I hereby authorize service be performed and assign that benefits be payable to Laboratory. I understand that if any insurer doesn't pay and denies the claim, I am responsible for payment including, but not limited to, non-coverage and non-authorized services. I further authorize the testing laboratory and my physician to release to my insurance provider any medical information necessary to this claim.	
CC: PHYSICIAN / **FAX #**			
CITY / **STATE** / **ZIP CODE**		**PATIENT/RESPONSIBLE PARTY SIGNATURE:** / **DATE:**	
ICD-10 CODE / **ICD-10 CODE** / **ICD-10 CODE**			

NOTES & ADDITIONAL TEST REQUESTED

For complete test menu visit www.HCCL.COM

Test Code:

PANELS/PROFILES		
3341		**Basic Metabolic Panel** – Glu, BUN, Creat, Na, K, Cl, CO2, Gap, Ca
3199		**Comprehensive Metabolic Panel** - Na, K, Cl, Glu, BUN, CO2, Ca, Creat, TP, Alb, T Bil, Alk Phos, AST, ALT
3117		**Electrolyte Panel** – Na, K, Cl, CO2
3192		**Hepatic Function Panel** – Alb, Alk Phos, DBIL, TBIL, TP, AST, ALT
8216		**Hepatitis Acute Panel** – HbsAg, HBcAB-IgM, HCV
3181		**Lipid Panel** – Chol, Trig, HDL, Chol/HDL ratio, LDL
7848		**Thyroid Panel** – T4, T-Uptake, FTI

MICROBIOLOGY		
Source Required:_____		
2050		Routine Culture
6632		Enteric Pathogens - PCR
2100		Urine Culture
6615		C DIFF - PCR
6631		COVID 19 - PCR
8089		CT/NG – PCR
1191		Flu A/B – PCR
6649		Group B Strep - PCR
1192		RSV - PCR
1185		Strep A (Throat) - PCR

HEMATOLOGY		
1123		CBC (Hemogram & Auto Diff)
1173		Sed Rate
1223		PT-Anticoagulant
1228		PTT - Anticoagulant

5016		Urinalysis

TEST w/REFLEX		
8005		ANA (Reflex: Anti-Centromere, dsDNA QN, Anti-SS-A/Ro, Anti-SS-B/La, Anti-Smith, Anti-RNP, Anti-Jo-1)
8289		HIV (Reflex: Confirm Test)
8258		Syphilis IgG/IgM (Reflex: RPR)

*Please note: Reflex tests are performed at an additional charge.

CHEMISTRY											
8003		AFP (non-maternal)	3072		Calcium	3132		Glucose, Fasting	8145		Rubella IgG
3018		Albumin	3086		CPK	3227		HCG, Quant	7830		T3, Total
3258		ALT/SGPT	3094		Creatinine	7623		Hemoglobin A1C	7844		T4 (thyroxine)
3034		Amylase	8049		CEA	8060		Hepatitis C Ab	7842		T4, Free
4003		Antibody Screen	8211		COVID 19 Ab	8289		HIV- 1,2 Ab	7827		TSH
3256		AST/SGOT	3109		CRP	8082		Immunoglobulins, Quant	7841		TSH/Free T4
3058		Bilirubin - Direct	7549		CRP Cardio	3160		Iron, Total	3068		Urea Nitrogen (BUN)
8052		C3	7567		DHEA Sulfate	3281		Iron/Transferrin/TSI	3276		Uric Acid
8053		C4	7577		Ferritin	3194		Magnesium	7870		Vitamin B12
8046		CA 15-3	7579		Folate, Serum	3212		Phosphorus	7850		Vitamin D
8051		CA 125	3124		GGT	7675		PSA Screening			

X_____ _____

PHYSICIAN SIGNATURE **DATE**