DYNIX DIAGNOSTIX

Dynix Diagnostix
2260 N US Highway 1
Fort Pierce, FL 34946
Phone: (844) 514-8158 • dynixdiagnostix.com

Blood Laboratory Request

X000000

CLINIC/PHYSICIAN INFORMATION

PATIENT'S / INSURANCE INFORMATION

Last Name First Name MI

___/___/___ M ☐ F ☐ XXX / XX / ______

D.O.B. Last 4 digits of SS#

Address

City, State ZIP

Phone Number

Insurance

Policy Number Group Number

☐ Insurance ☐ Self Pay

PLEASE ATTACH COPY OF PATIENT FACE SHEET AND INSURANCE CARD

SPECIMEN DATA

Fasting patient: ☐ Yes ☐ No

Date Collected:______/______/______ Time:_____:_____ AM PM

Collector Name:________________________________

ICD-10 DIAGNOSIS CODE(S)

________________ ________________

________________ ________________

PATIENT PRESCRIBED MEDICATIONS

________________ ________________

________________ ________________

________________ ________________

TESTS REQUESTED

☐ CUSTOM PANEL G = Gold, R = Red, L = Lavender, P = Probe, U = Urine, S = Swab, TG = Tiger

✓ PANELS	ICD-10	Calcium (G/TG/R)	
Basic Metabolic Panel (G/TG/R)		Chloride (G/TG/R)	
CBC (L)		Cholesterol, Total (G/TG/R)	
CBC w/ Diff (L)		CO2 (G/TG/R)	
Comprehensive Metabolic Panel (G/TG/R)		Creatine Kinase (G/TG)	
Electrolyte Panel (G/TG/R)		Creatinine (G/TG/R)	
Hepatic Function Panel (G/TG/R)		GGT (G/TG/R)	
Lipid Panel (G/TG/R)		Glucose (G/TG/R)	
Renal Function Panel (G/TG/R)		HDL (G/TG/R)	
Southern Allergy Panel (R)		Iron (G/TG/R)	
THYROID TESTS		Lipase (G/TG)	
TSH (G/R)		Magnesium (G/TG/R)	
Free T3 (R)		Phosphorus (G/TG/R)	
Free T4 (G/R)		Potassium (G/TG/R)	
TgAb (G/R)		Protein, Total (G/TG/R)	
Total T3 (R)		Rheumatoid Factor (R)	
Total T4 (G/R)		Sodium (G/TG/R)	
TPoAg (G/R)		Total Iron Binding Capacity (G/TG/R)	
TSH3G (G/R)		Triglycerides (G/TG/R)	
CARDIAC TESTS		Uric Acid (G/TG/R)	
CKMB (TG)		VITAMIN/OTHER	
Myoglobin (TG)		Ferritin (G/TG/R)	
Troponin I (TG)		Folate (R)	
HORMONE TESTS		Homocystine (G/TG/R)	
ACTH (L)		IgE (G/TG/R)	
Cortisol (R)		Vitamin B12 (R)	
DHEA (R)		Vitamin D (G/TG/R)	
Estradiol (R)		DIABETES	
FSH (R)		C-peptide (G/TG/R)	
HGH (R)		HgbA1C (L)	
LH (R)		Insulin (G/TG/R)	
PRL (R)		KIDNEY TESTS	
Progesterone (R)		BMG (G/TG/R)	
SHBG (R)		Cystatin C (G/TG/R)	
Testosterone (R)		PTH (L)	
MICRO/MOLECULAR TESTS		TUMOR MARKERS	
Influenza A&B (S)		AFP (G/TG/R)	
MRSA Probe (S)		CA 125 (G/TG/R)	
HEMATOLOGY		CA 19-9 (G/TG/R)	
Hemoglobin/Hematocrit (L)		CA 27.29 (G/TG/R)	
Platelets (L)		CEA (G/TG/R)	
BLOOD CHEMISTRY		PA (G/TG/R)	
Albumin (G/TG/R)		SEXUAL HEALTH	
Alkaline Phosphatase (G/TG/R)		Chlamydia (U)	
ALT/SGPT (G/TG/R)		Gonorrhea/Chlamydia RNA Probe (U)	
Amylase (G/TG)		HCG (U)	
AST/SGOT (G/TG/R)		RPR (R)	
Bilirubin, Direct (G/TG/R)		Trichomoniasis (U)	
Bilirubin, Total (G/TG/R)		THERAPEUTIC DRUG MONITORING	
BUN (G/TG/R)		Lithium (G/TG/R)	

☐ OTHER ________________________________

PHYSICIAN AUTHORIZATION:

I authorize the laboratory test(s) as ordered, and affirm that each are both medically necessary and correspond to the patient's diagnosis as submitted to the laboratory for testing. I understand that each test I order is a billable event, and the patient's medical record(s) must clearly reflect my order.

Ordering Physician Signature (Required) Date

PATIENT AUTHORIZATION:

I voluntarily consent to the collection and testing of my specimen. I understand that I am responsible for all co-pays, deductibles, and amounts not covered by my insurance. I assign to Dynix Diagnostix, LLC all insurance payment(s) made for any laboratory services provided to me and direct same to represent me in any grievances or appeals process relating to the payment of these laboratory services. I consent to the release of any medical records necessary to process any insurance claim(s).

Patient Signature (Required) Date

Patient Name:________________ DOB:________________
Collection Date:________________ Collector's Name:________________

[BARCODE HERE]

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Patient Name:________________ DOB:________________
Collection Date:________________ Collector's Name:________________

[BARCODE HERE]

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