

PATIENT INFORMATION

Patient Name

DOB: ____ / ____ / ____

Gender Male Female

Referring Physician: _____

Phone: _____

NPI: _____

Fax: _____

Diagnosis Code: _____

Routine STAT Report

Referring Physician Signature: _____

Date: _____

X-RAY

- Sinuses 3V
- Cervical Spine 2V / 4-5V
- Chest 1V / 2V
- Ribs Unilateral with PA Chest R / L
- Ribs Bilateral with PA Chest
- Thoracic Spine 3V
- Abdomen 2V
- Abdomen Complete with Chest
- KUB
- Lumbar Spine 2 -3V / 4V
- Lumbar Spine Bending Views Only
- Pelvis AP Only

Extremities: R | L

- | | |
|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Clavicle | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Femur |
| <input type="checkbox"/> Humerus | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Tib / Fib |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Calcaneous |
| <input type="checkbox"/> Finger | <input type="checkbox"/> Toe |

Other: _____

CT

IV Contrast: W/O W W+W/O

- Brain
- Sinus / Maxillofacial
- Orbit / IAC
- Soft Tissue Neck
- Cervical Spine
- Chest
- Thoracic Spine
- Abdomen
- Abdomen + Pelvis | Oral Contrast
- Lumbar Spine
- Pelvis
- CTA Head
- CTA Neck
- Chest high resolution

Extremities: R | L

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Humerus | <input type="checkbox"/> Femur |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Tib / Fib |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Foot |

Other: _____

ULTRASOUND

- Lung Screening
- Calcium Score
- CTA Chest
- CTA Abdomen + Pelvis
- Aorta
- Abdominal Limited
- Abdominal Complete
- Pelvic (Complete)
- Pelvic (Transvaginal)
- Renal
- UB Pre + Post-Void
- OB First Trimester
- OB Complete > 14 Weeks
- Scrotal / Testicular
- Thyroid
- Soft tissue Neck
- Carotid
- Renal Artery Doppler
- Arterial Doppler Lower Extremity R / L
- Venous Doppler Lower Extremity R / L
- Extremity Non-Vascular R / L

Other: _____

REQUIRED: If faxing order form, include patient face sheet with insurance information.



11903-B Panama City Beach Pkwy,
Panama City Beach, FL 32407
Phone: (850) 353-0187
Fax: (850) 331-1595

Patient Name: _____
Patient Phone: _____
Date of Birth: _____
Gender: _____

Insurance Bill Patient Bill Client Bill

= In-House Lab (Same Day Results)*
*Labs drawn prior to 3PM

Panels		Individual Tests		Individual Tests (cont.)		Molecular Tests	
BMP		ESR (Sed Rate)		T3 Free		PCR Wound	
CMP		Estradiol		T3 Total		PCR Urine	
CBC w/ Auto Differential		Ferritin		T4 Free		PCR Nail	
Electrolyte Panel		Folate/Folic Acid		T4 Total		Urine Tox (Medical)	
Hepatic Function Panel		Follicle Stimulating Hormone (FSH)		TSH		Other Tests	
Hepatitis Panel		Gamma Glutamyl Transferase (GGT)		TSH with Reflex Free T4			
Lipid Panel		Glucose Serum/Plasma		Testosterone, Free			
Renal Function Panel		HDL Cholesterol		Testosterone, Total			
Individual Tests		Hematocrit		Thyroglobulin			
ABO Rh Type		Hemoglobin		Thyroglobulin AB		Diagnosis Code(s)	
Albumin		Hemoglobin A1C		Thyroid Peroxidase AB		1. _____	
Albumin:Creatinine Ratio		Homocysteinine		Triglycerides		2. _____	
Alkaline Phosphatase		Insulin		Troponin-I		3. _____	
ALT (SGTP)		Iron, Total		Uric Acid		4. _____	
Ammonia		Iron Binding Capacity, Total (TIBC)		Urinalysis		5. _____	
Amylase		Lactate Dehydroganase (LDH)		Urine Culture			
Anti-Mullerian Hormone (AMH)		LDL Cholesterol, Direct		Vitamin B12			
Anti-Nuclear Antibody (ANA)		Lead		Vitamin D 1,25-Dihydroxy			
AST (SGOT)		Leutinizing Hormone (LH)		Vitamin D, 25-Hydroxy			
BNP		Lipase		Zinc			
Bilirubin, Direct		Magnesium		ID and Screening		Referring Provider	
Bilirubin, Total		Phosphorus		COVID-19 PCR		Provider Name (Print)	
BUN		Potassium		FLU A&B/RSV/Influenza PCR		_____	
CA-125		Preg hCG, Serum (Qualitative)		GC/Chlamydia (Urine) PCR		Signature	
Calcium		Preg hCG, Serum (Quantitaitve)		Fecal Occult Blood Test (FOBT)		_____	
CEA		Progesterone		H. Pylori Screen		Phone	
Cholesterol		Prolactin		Hepatitis A Antibody IgM		_____	
Cortisol		Protein, Total		Hepatitis B Surface Antibody		Phone	
Creatine Kinase (CK)		PSA, Total		Hepatitis B Surface Antigen		_____	
Creatinine		PSA, Free		Hepatitis B Viral Load		Phone	
Creatinine Clearance 24 HR Urine		PT/INR		Herpes HSV 1 & 2 AB IgG		_____	
CRP (C-Reactive Protein)		aPTT		HIV Confirm Antibodies/Antigen		Fax	
CRP, High Sensitivity		PTH Intact (Parathyroid Hormone)		Infectious Mononucleosis Screen		_____	
D-Dimer		Reticulocyte count		Influenza Type A		Date	
DHEA-S		Rheumatoid Factor (RF)		Influenza Type B		_____	
Drug Screen, Serum		Sodium		Measles/Mumps/Rubella			
Drug Screen, Urine		Sex Hormone Binding Globulin (SHBG)		Cytomeglovirus (CMV) Viral Load			