Patient Name:
MR #:
CSN#:
DOB: dd-mmm-yyy y Age: Sex:
Date/time: dd-mmm-yyy y

Manually Complete or Attach Label with required data

Monroe Carell Jr. Children's Hospital at Vanderbilt
Where discovery brings hope

Document Type Bar Code Here

VCH Downtime &/or Code Requisition

Diagnostic Laboratory 4605 TVC, Nashville, TN 37232

Month:	**Day:**	**Year:**	**Collection Time:** ____**a.m.** _____**p.m.**	**Ordering Dept./Service:**	**Collection Location:**	**Allergies:**
Ordering Physician:			**Physician Beeper/Phone:**	**Height:** _____**Weight**_____	**Unit/Bed:**	☐ **STAT LAB**

MAIN LAB (Multiple Lab Tests Can Be Ordered) (Tubes: 109, 606, 801) ICD 10 CODE:

#	Lab Code	Chemistry	Tube Color
	ABL	Albumin	LGN
	AMY	Amylase	LGN
	BMP	**Basic Metabolic Panel** (Elec, Glu, Bun, Crea, CA)	LGN
	BHC	Beta HCG, Serum	LGN
	TBR	Bilirubin, Total	LGN
	CA	Calcium	LGN
	CO2	Carbon Dioxide	LGN
	CL	Chloride	LGN
	CHL	Cholesterol	LGN
	CK-MB	CK-MB CK Ratio	LGN
	CMP	**Comp Metabolic Panel** (BMP, TBIL,Alk Phos, PRO, AST,ALT)	LGN
	CRE	Creatinine	LGN
	GLU	Glucose	LGN

#	Lab Code	Chemistry	Tube Color
	LDH	LDH, Blood	LGN
	MG	Magnesium	LGN
	OSM	Osmolality	LGN
	PO4	Phosphorus, Inorganic	LGN
	K	Potassium	LGN
	PRO	Protein Total, Blood	LGN
	ALT	SGOT	LGN
	NA	Sodium	LGN
	TGL	Triglycerides	LGN
	TRI	Troponin I	LGN
	UAB	Uric Acid	LGN
		Other:	
		Other:	

#	Lab Code	Hematology	Tube Color
	CBP	CBC/Platelets	LV
	CPD	CBC/Platelets/ Diff	LV
	HCT	Hematocrit	LV
	PLT	Platelets	LV
#	**Lab Code**	**Coagulation**	**Tube Color**
	DDI	D-Dimer for DIC, Quant	LB
	FBG	Fibrinogen	LB
	PT	Prothrombin Time	LB
	PTT	Partial Throm-boplastin Time	LB
#	**Lab Code**	**Toxicology**	**Tube Color**
	DIG	Digoxin Date/time last dose:	DGN
	DSA	Drug Profile (U)	UR
	PYT	Phenytoin (Dilantin) Date/time last dose:	DGN

#	Lab Code	Body Fluids	Tube Color
	CSF	CSF Cell Count (Body Fluid Container)	
	SFG	CSF, Glucose (Sterile Plastic LP Tube)	
	SFP	CSF, Protein (Sterile Plastic LP Tube)	
	UCG	Pregnancy Test, Urine	**UR**
	UA1	Urinalysis	**UR**
	OSU	Urine Osmolality **(ARUP # 0020228)**	**UR**
#	**Lab Code**	**Other**	**Tube Color**
	ABG	Blood Gas, Arterial	
	VBG	Blood Gas, Venous	
	CAI	Ionized Calcium	**Full Dark Green**
		Other:	
		Other:	

Ancillary Departments: <u>One</u> (1) department/product per form

Requested Order/s:_____

Reason/History/Diagnosis/ICD 10 Code _____

☐ Peds Nutrition (Phone3-9763 Fax 3-8810)

☐ *Non-MD Consult_____

☐ Miscellaneous_____

☐ Peds Respiratory (Phone 715-9014 Fax 6-4351)

☐ Peds Echo (Phone 6-2481, Fax 3-1432)

☐ Peds Pulmonary Function (Phone 6-2556, Fax 6-3665)

☐ Peds Radiology Phone: 6-7155, Fax: 3-1841

☐ Social Work (beep SW)

Other:

Collector's Print Name:	**Collector's Signature:**	**Collection Date/Time:**	**Collector's Vunet ID**