

**BASSETT HEALTHCARE NETWORK
GLUCOSE TOLERANCE
LAB TEST REQUEST FORM #8**

#7031(f:\lab\doc) 10/27/06,4/07, 8/1/07,1/14/08,
8/1/07,1/14/08,4/7/08,10/6/08,4/6/09,1/4/10,3/29/10,7/19/10,
1/3/2011,11/29/11,1/16/12,7/1/13,1/6/14,10/6/14,1/5/15, 5/14/15,
8/10/15,9/7/23, 2/16/26

Date of Request _____ Visit Number _____

Ordering Provider: _____
Medicaid ID: _____

Chart #: _____ Location: _____

Attending Provider: _____

Name Last: _____ First: _____

Please circle requests below.

Date of Birth _____ Medicaid ID#: _____

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

Diagnosis Code: or Descriptive Diagnosis:

PROVIDERS: Compliance is mandatory and regulated. For the laboratory to bill properly and receive payment, you must provide the specific Diagnosis codes for each outpatient test ordered. Additionally, only tests that are medically necessary for the indicated diagnosis or treatment should be ordered, with supporting documentation in the medical record. For tests included in each panel and reflexive testing, please refer to the back of the requisition form. Under current Medicare regulations, when certain laboratory tests (indicated by an *) are ordered, and the diagnosis is not listed in the Local Coverage Determination or National Coverage Determination for that test, payment may be denied. In these cases Medicare requires an Advance Beneficiary Notice (waiver of liability) be signed to allow the hospital to bill the patient. The ABN box on the requisition **MUST** be checked when an ABN is obtained. **Patient has signed ABN Waiver (ABN)** **Patient refused to sign ABN Waiver (ABNR)** **ABN not required**

Refer to the Oral Glucose Tolerance Testing Procedure located on the Bassett Intranet Laboratory Manual Document Center for full instructions.

PATIENT INSTRUCTIONS

1. Have the patient eat a carbohydrate intake of at least 150 g/day for 3 days before the test.
2. Have the patient fast for 8-12 hours. Fasting includes abstinence from tobacco, coffee, tea, juice, alcohol, food, mints, gum, etc. – only water to drink.
3. Patient should sit upright and quietly during the test.

PROVIDER INFORMATION

1. Perform GTT only on patients with known fasting glucose <126 mg/dl. Before a glucose load is given, obtain a fasting glucose sample. In some cases, it may be necessary to wait for the fasting glucose value before administering the oral glucose dose.
2. Note on the lab requisition the appropriate test, the dose of Glucola given, and the time the Glucola was given.

NURSE INFORMATION:

Fasting Glucose Screen: _____ mg/dl _____ time/date Initials: _____

Glucola Administered: _____ vol _____ time/date Initials: _____

GLUCOSE TOLERANCE TESTS FOR PREGNANT OR POSTPARTUM WOMEN

Select Test	LIS Code	Glucose Testing Performed	Usage
Pregnant or Postpartum Women			
	LAB3583*	1 hr draw post Glucola	Screen (50 G) used AS Gestational Diabetes Challenge
	LAB3000	Fasting, 1, 2 hr glucoses	Standard OGTT (75g). Used for gestational
	LAB169*	Fasting and 2 hr glucose	Standard OGTT (75g). Used 6 weeks postpartum.
	LAB3545	Fasting, 1 hr, 2 hr, 3 hr glucose	Follow-up testing from failed 1 GCT (100g).

GLUCOSE TOLERANCE TESTS FOR NON-PREGNANT ADULTS AND PEDIATRICS

Select Test	LIS Code	Glucose Testing Performed	Usage
	LAB169*	Fasting, 2 hr glucose	Standard OGTT (75 g).
	LAB164	Fasting, 1, 2, 3 hr glucose	ADA Obsolete Screen (100g)
	LAB167	Fasting, 1, 2, 3, 4, 5 hr glucoses	Screen for reactive hypoglycemia. Performed under provider supervision. Provider can stop the test at any time. (75 g)

GROWTH HORMONE SUPPRESSION TEST

Select Test	LIS Code	Glucose Testing Performed	Usage
	LAB2428	Fasting, ½, 1, 1½, 2 glucoses and GH	Growth Hormone Suppression Test (100 g)

OTHER TESTING

Provider's Signature: _____ Signed Date and Time: _____ Received by: _____
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REQUISITIONS Lab