

Date of Request _____ Visit Number: _____

Ordering Provider: _____
Medicaid ID: _____

Chart # _____ Location: _____

Attending Provider: _____

Name Last: _____ First: _____

Date of Birth _____ Medicaid ID#: _____

SPECIMEN	TIME: _____	DATE: _____
COLLECTED BY: _____		

Diagnosis Code: _____ or _____ Descriptive Diagnosis: _____

****BRING TO LAB ON T2****

***** DO NOT USE THIS AS AN ORDER UNLESS FOR DOWNTIME – RELEASE ORDERS FROM EPIC*****

28 WEEK WORKUP

Please circle requests below

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).

RHOGAM ORDERS (INCLUDES TSC)

Code	Test Name
LAB21075	Antepartum Rhogam

Check One:

- Micro Dose (12 weeks gestation or less)
- Full Dose

Rhogam Needed:

Date: _____
Time: _____
Location: _____

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