# EPIC Downtime Lab Orders

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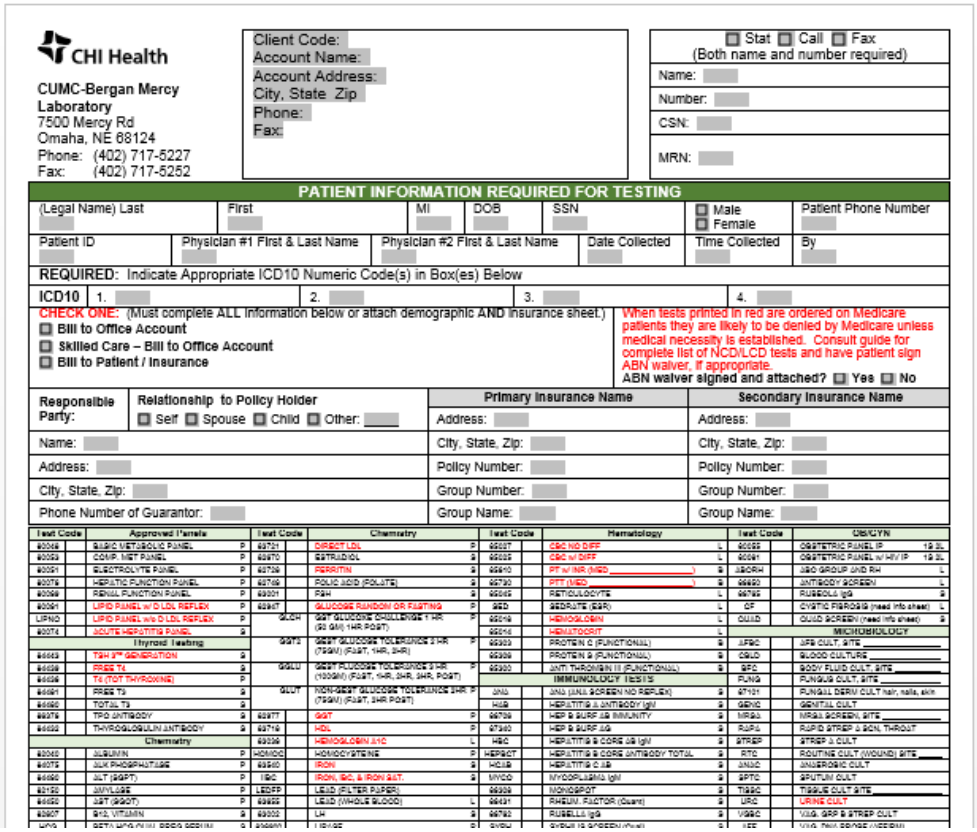
## EPIC Downtime Procedure for Lab Orders

In the event that the EPIC application is failing to respond, follow this procedure for ordering labs on downtime requisitions. This will ensure orders are able to be entered without issues and results will still be available in a timely manner.

Procedure includes:

- General Lab Downtime Requisition Instructions
- Anatomic Pathology Downtime Requisition Instructions
- EPIC Downtime Requisition Instructions

Locate your Green Gen Lab downtime requisitions. If unable to locate these requisitions, print the Green Gen Lab requisition from the Lab website (FORMS page), or utilize the requisition in your EPIC downtime packet. See below.



CHI Health

CUMC-Bergan Mercy Laboratory
7500 Mercy Rd
Omaha, NE 68124
Phone: (402) 717-5227
Fax: (402) 717-5252

Client Code:
Account Name:
Account Address:
City, State Zip
Phone:
Fax:

☐ Stat ☐ Call ☐ Fax
(Both name and number required)
Name:
Number:
CSN:
MRN:

**PATIENT INFORMATION REQUIRED FOR TESTING**

| (Legal Name) Last | First | MI | DOB | SSN | ☐ Male ☐ Female | Patient Phone Number |
|---|---|---|---|---|---|---|
| Patient ID | Physician #1 First & Last Name | Physician #2 First & Last Name | Date Collected | Time Collected | By | |

**REQUIRED:** Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below

ICD10 1. 2. 3. 4.

**CHECK ONE:** (Must complete ALL information below or attach demographic AND insurance sheet.)
☐ Bill to Office Account
☐ Skilled Care – Bill to Office Account
☐ Bill to Patient / Insurance

When tests printed in red are ordered on Medicare patients they are likely to be denied by Medicare unless medical necessity is established. Consult guide for complete list of NCD/LCD tests and have patient sign ABN waiver, if appropriate.
ABN waiver signed and attached? ☐ Yes ☐ No

| Responsible Party: | Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other: | Primary Insurance Name | Secondary Insurance Name |
|---|---|---|---|
| Name: | | Address: | Address: |
| Address: | | City, State, Zip: | City, State, Zip: |
| City, State, Zip: | | Policy Number: | Policy Number: |
| Phone Number of Guarantor: | | Group Number: | Group Number: |
| | | Group Name: | Group Name: |

| Test Code | Approved Panels | P | Test Code | Chemistry | P | Test Code | Hematology | L | Test Code | OB/GYN | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 80048 | BASIC METABOLIC PANEL | P | 83721 | DIRECT LDL | P | 85027 | CBC NO DIFF | L | 80055 | OBSTETRIC PANEL (P | 12 SL |
| 80053 | COMP. MET PANEL | P | 82570 | CREATININE | P | 85025 | CBC w/ DIFF | L | 80081 | OBSTETRIC PANEL w/ HIV (P | 12 SL |
| 80051 | ELECTROLYTE PANEL | P | 82728 | FERRITIN | P | 85610 | PT w/ INR (MED_____) | P | 86900 | ABO GROUP (AND RH | L |
| 80076 | HEPATIC FUNCTION PANEL | P | 82746 | FOLIC ACID (FOLATE) | P | 85730 | PTT (MED_____) | P | 86850 | ANTIBODY SCREEN | L |
| 80069 | RENAL FUNCTION PANEL | P | 83001 | FSH | P | 85045 | RETICULOCYTE | L | 86765 | RUBEOLA IgG | P |
| 80061 | LIPID PANEL w/ D LDL REFLEX | P | 82947 | GLUCOSE RANDOM OR FASTING | P | 85651 | SED RATE (ESR) | L | CF | CYSTIC FIBROSIS (need info sheet) | L |
| LIPNO | LIPID PANEL w/o D LDL REFLEX | P | GLCH | GXT GLUCOSE CHALLENGE 1 HR (50 GM) 1HR POST) | P | 85049 | HEMOGLOBIN | L | CLUID | CLUID SCREEN (need info sheet) | P |
| 80074 | ACUTE HEPATITIS PANEL | P | | | | 85046 | HEMATOCRIT | L | | MICROBIOLOGY | |
| | Thyroid testing | | GXT3 | GEST GLUCOSE TOLERANCE 3 HR (75GM) (FAST, 1HR, 2HR) | P | 85303 | PROTEIN C (FUNCTIONAL) | P | AFBC | AFB CULT, SITE | |
| 84443 | TSH 3RD GENERATION | P | | | | 85306 | PROTEIN S (FUNCTIONAL) | P | CBLD | BLOOD CULTURE | |
| 84439 | FREE T4 | P | GGLU | GEST GLUCOSE TOLERANCE 5 HR (100GM) (FAST, 1HR, 2HR, 3HR, POST) | P | 85300 | ANTI THROMBIN III (FUNCTIONAL) | P | BFC | BODY FLUID CULT, SITE | |
| 84436 | T4 (TOT THYROXINE) | P | | | | | IMMUNOLOGY TESTS | | FUNG | FUNGUS CULT, SITE | |
| 84481 | FREE T3 | P | GLUT | NON-GEST GLUCOSE TOLERANCE 3HR (75GM) (FAST, 2HR POST) | P | UNG | UNG (UNA SCREEN NO REFLEX) | P | 87101 | FUNGAL DERM CULT hair, nails, skin | |
| 84480 | TOTAL T3 | P | | | | HIVB | HEPATITIS A ANTIBODY IgM | P | GENC | GENITAL CULT | |
| 86376 | TPO ANTIBODY | P | 82977 | GGT | P | 86709 | HEP B SURF AB IMMUNITY | P | MRSO | MRSA SCREEN, SITE | |
| 84558 | THYROGLOBULIN ANTIBODY | P | 83718 | HDL | P | 87340 | HEP B SURF AG | P | RUPO | RUP.O STREP A SCRN, THROAT | |
| | Chemistry | | 83036 | HEMOGLOBIN A1C | L | HBC | HEPATITIS B CORE AB IgM | P | STREP | STREP A CULT | |
| 82040 | ALBUMIN | P | HOMOC | HOMOCYSTEINE | P | HEPBCT | HEPATITIS B CORE ANTIBODY TOTAL | P | RTC | ROUTINE CULT (WOUND) SITE | |
| 84075 | ALK PHOSPHATASE | P | 83540 | IRON | P | HCAB | HEPATITIS C AB | P | ANSC | ANSEROBIC CULT | |
| 84460 | ALT (SGPT) | P | IBC | IRON, IBC, & IRON SAT. | P | MYCO | MYCOPLASMA IgM | P | SPTC | SPUTUM CULT | |
| 82150 | AMYLASE | P | LEDFP | LEAD (FILTER PAPER) | | 86308 | MONOSPOT | P | TISC | TISSUE CULT SITE | |
| 84450 | AST (SGOT) | P | 83655 | LEAD (WHOLE BLOOD) | L | 86431 | RHEUM. FACTOR (Quant) | P | URC | URINE CULT | |
| 82607 | B12, VITAMIN | P | 83550 | LH | P | 86762 | RUBELLA IgG | P | VGBC | VAG, GBP & STREP CULT | |
| | | | | | | | | | | | |

# EPIC Downtime Lab Orders

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1. Ensure that your **Clinic Name and Location and Clinic Code** are correct in the header.
    a. **A Clinic Code is present on the preprinted Green Gen Lab downtime requisitions**. Each clinic code is tied to information about the clinic. The clinic code drives billing, who is contacted if there are specimen problems, who is contacted if there are critical results.
    b. If you print the green Gen Lab Requisition from the website, you MUST write your clinic name and clinic code on the header of the requisition. If you do not know your clinic code, contact Lab at 402-717-5227.
2. **Call/Fax:** If lab results are to be called or faxed, mark the appropriate box at the top right corner, name of fax recipient, and secure fax number.
3. The top half of the General Reference lab requisition must be filled out completely.
    a. **Patient's Legal Name:** Required. Print patient's last name, first name and middle initial.
    b. **Patient's Social Security Number:** Necessary, if available, for correct identification.
    c. **Patient's Date of Birth**: Required. Acceptable format is Month, Day, Year.
    d. **Patient's Sex:** Required. Male or Female; checkmark appropriate box
    e. **Patient's Phone #:** Phone number will appear on the patient's lab report to aid physician contacting patient.
    f. **Patient ID:** This field is for MRN.
    g. **Physician #1:** Required. Print ordering physician's First and Last name
    h. **Physician #2:** For copy to another provider, print provider's First and Last name.
    i. **Date Collected:** Required. Acceptable format is Month, Day, Year
    j. **Time Collected:** Required. Use Military time (ie 0900, 1400) or conventional time (ie 9:00am/2 pm)
    k. **Collected By:** Required. Print first initial and full last name (ie S. Jones)
    l. **ICD10 CODE Diagnosis:** Required. Acceptable format is alphanumeric coded diagnosis. Narrative or descriptive codes will not be accepted.
    m. **Bill to:** Required. Bill Type must be identified. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance. If Bill to Patient/Insurance, insurance information MUST be filled out on form or a demographic sheet attached.
        i. A copy of the front and back of the insurance card is required.
    n. **Insurance Information Required**
        i. Guarantor/Responsible Party (if other than patient): (Insured party's information)
        *SSN# of Guarantor: (Insured party's SSN)*
        Address, City, State, Zip

        ii. PRIMARY Insurance: Name of Insurance Company
        Policy #:

Group #:
Address of Payer

iii. SECONDARY Insurance: Name of Insurance Company
Policy #:
Group #:
Address of Payer

4. The bottom half of the General Reference Lab Requisition:
    a. **Medicare Limited Coverage Tests are printed in RED.** Refer to NCD/LCD Covered Codes available online on Lab website for diagnosis codes that meet compliance. If none of the codes are acceptable, an ABN (Advanced Beneficiary Notice) waiver must accompany the requisition. The ABN must be signed by the patient PRIOR to the service being performed. Please acknowledge whether a waiver has been signed and attached to the requisition.
        i. Keep a copy of the ABN at the clinic to scan into EPIC.
    b. **Tests:** Listed are the most common tests with the CPT codes for CHI Health Lab. The AMA (American Medical Association) approved panels are listed first on the left hand side of the requisition. All other tests are listed under the subtopics of THYRIOD TESTING, CHEMISTRY, DRUG LEVELS, HEMATOLOGY, IMMUNOLOGY TESTS, URINE TESTING, OB/GYN, AND MICROBIOLOGY TESTING.
    c. **Marking Tests:** Mark the box to the left of the test name and keep within the boundary of the box. Testing could be delayed if clarification is needed for testing ordered.
    d. **Tube Code:** On the right hand side of the test box, across from the test name the tube type is indicated with a letter. See Key explaining abbreviations at the bottom of the requisition.
    e. **Additional Information**: When appropriate, complete any additional prompts for information. Examples are drug level dosage, total urine volumes, patient height and weight with appropriate units, and antibiotic information.
    f. **Unlisted Tests**: Use the blank space at the bottom right under Additional tests to write in any testing requested that is not listed. Provide a complete description of the requested test. No Abbreviations. Utilize online Lab test directory for correct name.
5. **Online Lab User's Guide**: Refer to the web page www.CHIhealth.com/laboratory for instructions on proper handling of specimens including tube types, specimen processing, "order of draw" and transport temperature.

6. **Specimen Labeling:** All Specimens are **required** to be labeled with: Patient's Last Name, Patient's First Name, Date of Birth, Collection Date and Time, and initials of collector.
    a. Always label specimens in the presence of the patient.
    b. Bar-coded labels will not print if EPIC is unable to send orders to Cerner (lab IT system).
    c. If submitting any molecular or microbiology specimens, include the source of the specimen.
7. Separate the triplicate form.
    a. Send the top white sheet and the yellow sheet for billing with the specimen in the biohazard bag.
    b. **Keep the pink copy for your records and to follow-up on results**.
        i. If EPIC is down, results may not go back into patient's chart.
        ii. Track the results by using the orders on the pink sheets.
        iii. Call lab if there are outstanding results.

# EPIC Downtime Lab Orders

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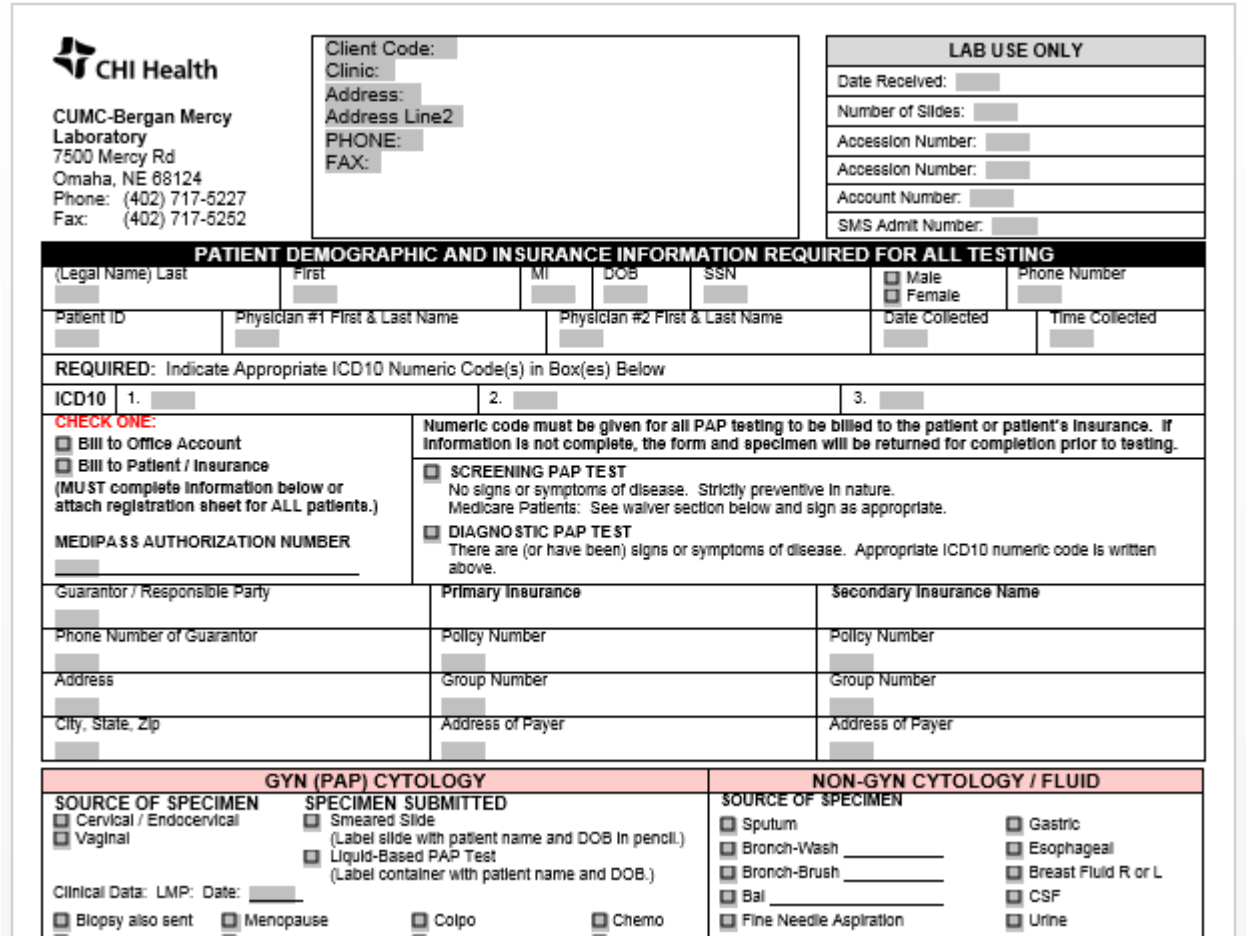
Locate your pink anatomic pathology downtime requisitions or print off the Anatomical Pathology Requisition (APR) from the lab website (FORMS page) for submitting any biopsies, tissues, pap smears, or non-gyn cytology during downtime.



CHI Health

CUMC-Bergan Mercy Laboratory
7500 Mercy Rd
Omaha, NE 68124
Phone: (402) 717-5227
Fax: (402) 717-5252

Client Code:
Clinic:
Address:
Address Line2
PHONE:
FAX:

LAB USE ONLY
Date Received:
Number of Slides:
Accession Number:
Accession Number:
Account Number:
SMS Admit Number:

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION REQUIRED FOR ALL TESTING

(Legal Name) Last | First | MI | DOB | SSN | Male / Female | Phone Number
Patient ID | Physician #1 First & Last Name | Physician #2 First & Last Name | Date Collected | Time Collected

REQUIRED: Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below

ICD10 1. 2. 3.

CHECK ONE:
Bill to Office Account
Bill to Patient / Insurance
(MUST complete information below or attach registration sheet for ALL patients.)

MEDIPASS AUTHORIZATION NUMBER

Numeric code must be given for all PAP testing to be billed to the patient or patient's insurance. If information is not complete, the form and specimen will be returned for completion prior to testing.

SCREENING PAP TEST
No signs or symptoms of disease. Strictly preventive in nature.
Medicare Patients: See waiver section below and sign as appropriate.

DIAGNOSTIC PAP TEST
There are (or have been) signs or symptoms of disease. Appropriate ICD10 numeric code is written above.

| Guarantor / Responsible Party | Primary Insurance | Secondary Insurance Name |
|---|---|---|
| Phone Number of Guarantor | Policy Number | Policy Number |
| Address | Group Number | Group Number |
| City, State, Zip | Address of Payer | Address of Payer |

GYN (PAP) CYTOLOGY

SOURCE OF SPECIMEN
Cervical / Endocervical
Vaginal

SPECIMEN SUBMITTED
Smeared Slide
(Label slide with patient name and DOB in pencil.)
Liquid-Based PAP Test
(Label container with patient name and DOB.)

Clinical Data: LMP: Date:
Biopsy also sent | Menopause | Colpo | Chemo

NON-GYN CYTOLOGY / FLUID

SOURCE OF SPECIMEN
Sputum
Bronch-Wash
Bronch-Brush
Bal
Fine Needle Aspiration
Gastric
Esophageal
Breast Fluid R or L
CSF
Urine

1. Ensure that your **Clinic Name and Location and Clinic Code** are correct in the header.
    a. **A Clinic Code is present on the preprinted Pink Anatomic Pathology Lab downtime requisitions**. Each clinic code is tied to information about the clinic. The clinic code drives billing, who is contacted if there are specimen problems, who is contacted if there are critical results.
    b. If you print the pink Anatomic Pathology Lab Requisition from the website, you MUST write your clinic name and clinic code on the header of the requisition. If you do not know your clinic code, contact Lab at 402-717-5227.

2. The top half of the Anatomic Path lab requisition must be filled out completely.
    a. **Patient's Legal Name:** Required. Print patient's last name, first name and middle initial.
    b. **Patient's Social Security Number:** Necessary, if available, for correct identification.
    c. **Patient's Date of Birth**: Required. Acceptable format is Month, Date, Year.
    d. **Patient's Sex:** Required. Male or Female; checkmark appropriate box
    e. **Patient's Phone #:** Phone number will appear on the patient's lab report to aid physician contacting patient.
    f. **Patient ID:** This field is for MRN.
    g. **Physician #1:** Required. Print ordering physician's First and Last name
    h. **Physician #2:** For copy to another provider, print provider's First and Last name.
    i. **Date Collected:** Required. Acceptable format is Month, Day, Year
    j. **Time Collected:** Required. Use Military time (ie 0900, 1400) or conventional time (ie 9:00am/2 pm)
    k. **Collected By:** Required. Print first initial and full last name (ie S. Jones)
    l. **ICD10 CODE Diagnosis:** Required. Acceptable format is alphanumeric coded diagnosis. Narrative or descriptive codes will not be accepted. Professional fees associated with anatomic pathology specimens require diagnosis codes.
    m. **Bill to:** Required. Bill Type must be identified. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance.
        i. A copy of the front and back of the insurance card is required.
    n. **Pathology Bill:** Insurance information **MUST** be filled out on all forms or a demographic sheet attached even if marked Bill to Office. CHI Pathology will bill professional fees to patient's insurance for part of the histology testing. Lab will bill technical fees to bill type marked.
    o. **Insurance Information Required**

    Guarantor/Responsible Party (of other than patient): (Insured party's information)
    *SSN# of Guarantor: (Insured party's SSN)*
    Address, City, State, Zip

    PRIMARY Insurance: Name of Insurance Company
    Policy #:
    Group #:
    Address of Payer

    SECONDARY Insurance: Name of Insurance Company
    Policy #:
    Group #:
    Address of Payer

3. **Pap:** Mark one box; select “Screening PAP test” for those PAPs that have no diagnostic reason except screening. Follow Medicare/Medicaid rules for an ABN if pap is performed before Medicare frequency guidelines. Select “Diagnostic PAP Test” for all PAPs that have signs or symptoms of disease.
4. **The bottom half of the Anatomic Pathology Lab requisition is separated into three sections:** Gynecological Tests, Non-Gyn Cytology Fluids, and Histology/Tissue Specimens
5. **Gynecological tests: Fill out for Pap GYN Cytology**
    a. Required. Indicate the source of the specimen. (Cervical, Vaginal, Endocervical)
    b. Required. Check whether the specimen is a smeared slide or a ThinPrep fluid.
    c. Required. Provide the date of the patient’s last menstrual period.
    d. Provide as much clinical information as possible.
    e. Record the date and diagnosis of the patient’s last Pap smear.
    f. Include any other pertinent clinical information in the comments area.
    g. Gonorrhea and Chlamydia boxes are available for Molecular testing on ThinPrep sample.
    h. HPV testing can be ordered regardless if pap is normal. ASCUS will automatically reflex to have HPV testing done.
6. **Non-Gyn Cytology Fluids**
    a. Required. Select the appropriate specimen source.
    b. If Fine Needle is selected, specimen site must be included.
    c. Designate whether the patient is on radiation therapy.
    d. Include any pertinent clinical history.
7. **Histology/Tissue Specimens**
    a. Required. Designate the source of the specimen and anatomic site/laterality. If more than one tissue is submitted, use the lines provided to indicate source and site in each numbered container on each corresponding line.
    b. Record the pre-op diagnosis.
    c. Record the patient’s clinical history.
    d. Record the post-op diagnosis if applicable.
    c. **Medicare Limited Coverage Test:** Mark whether ABN waiver is accompanying specimen and requisition. Refer to your NCD/LCD Covered Codes available online on Lab website for diagnosis codes that meet compliance. If none of the codes are acceptable, an ABN (Advanced Beneficiary Notice) waiver must accompany the requisition. The ABN must be signed by the patient PRIOR to the collection of the specimen. Please acknowledge whether a waiver has been signed and attached to the requisition.

   i. Keep a copy of the ABN at the clinic to scan into EPIC.
8. **Online Lab User's Guide**: Refer to the web page www.CHIhealth.com/laboratory for instructions on proper handling of specimens including transport temperature, ratios of formalin to tissue, and other information.
9. **Specimen Labeling:** All Specimens are **required** to be labeled with: Patient's Last Name, Patient's First Name, Date of Birth, Collection Date and Time, and initials of collector, AND site and source of specimen.
    a. Always label specimens in the presence of the patient.
    b. Bar-coded labels will not print if EPIC is unable to send orders to Cerner (lab IT system).
    c. The primary container needs to be labeled not the lids.
10. Separate the triplicate form.
    a. Send the top white sheet and the yellow sheet for billing with the specimen in the biohazard bag.
    b. **Keep the pink copy for your records and to follow-up on results**.
        i. If EPIC is down, results may not go back into patient's chart.
        ii. Track the results by using the orders on the pink sheets.
        iii. Call lab if there are outstanding results.

# EPIC Downtime Lab Orders

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If you do not have the triplicate preprinted forms or single copy requisition forms, utilize the downtime requisitions located in you downtime binder. See page 40 on EPIC Downtime Procedure BCA Policy and Forms.

_____ AH_____ P:_____ F:_____

HCP:_____ SHCP:_____

Name:_____ Sex:_____ DOB:_____ SSN:_____ EE#:_____

MRN#:_____ Enctr#:_____

GUAR:_____SEX:_____ DOB:_____ SSN:_____ EMPLR:_____

ADDR:_____ PH:_____

INS1:_____ ADDR:_____

ID:_____ GRP#:_____ GRP Name:_____

| Date Collected / Collected By | Time Collected | Indicate Medical Necessity for Medicare patients by recording Diagnosis Code that applies next to each test ordered. ICD9: 1._____ 2._____ 3._____ 4._____ | Call_____ Fax_____ (Both name and number required) Name:_____ Number:_____ FIN#:_____ FOR LAB USE |
|---|---|---|---|
| CHECK ONE: ☐ Bill to **Office Account** ☐ Bill to **Patient / Insurance** | When tests shaded in gray are ordered on Medicare patients they are likely to be denied by Medicare unless medical necessity is established. Consult guide for complete list of NCD/LCD tests and have patient sign ABN waiver if appropriate. ABN waiver signed and attached ☐ YES ☐ NO | | |

| Test Code | *Approved Panels* | | Test Code | *Chemistry* | | Test Code | *Hematology* | | Test Code | *OBGYN* | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 80048 | BASIC METABOLIC PANEL | S | CRPH | CRP, HIGH SENSITIVITY | S | 85027 | CBC NO DIFF | L | 80055 | OBSTETRIC PANEL 2S | 1P 1L |
| 80053 | COMP. MET PANEL | S | 83721 | DIRECT LDL | S | 85025 | CBC WITH DIFF | L | ABORH | ABO GROUP AND RH | P |
| 80051 | ELECTROLYTE PANEL | S | 82670 | ESTRADIOL | S | 85610 | PT ANTICOAG. w/INR (MED_____) | B | 86850 | ANTIBODY SCREEN | P |
| 80076 | HEPATIC FUNCTION PANEL | S | 82728 | FERRITIN | S | 85730 | PTT ANTICOAG. (MED_____) | B | 86765 | RUBEOLA IgG | S |
| 80069 | RENAL FUNCTION PANEL | S | 82746 | FOLIC ACID (FOLATE) | S | 85045 | RETICULOCYTE | L | CF | CYSTIC FIBROSIS (need info sheet) | S |
| 80061 | LIPID PANEL WITH D LDL REFLEX | S | 83001 | FSH | S | SED | SEDRATE (ESR) | L | QUAD | QUAD SCREEN (need info sheet) | S |
| LIPNO | LIPID PANEL WITHOUT D LDL REFLEX | S | 82947 | GLUCOSE RANDOM OR FASTING | S | 85018 | HEMOGLOBIN | L | TRIP | TRIPLE SCREEN (need info sheet) | S |
| 80074 | ACUTE HEPATITIS PANEL | 2S | GLCH | GEST. GLUCOSE CHALLENGE (50gm) (1HR POST) | S | 85014 | HEMATOCRIT | L | | | |
| | *Thyroid Testing* | | | | | 85303 | PROTEIN C (FUNCTIONAL) | | | *MICROBIOLOGY* | |
| 84443 | TSH 3RD GENERATION | S | GGLU | GEST. GLUCOSE TOL (100gm) (FAST, 1HR, 2HR, 3HR POST) | S | 85306 | PROTEIN S (FUNCTIONAL) | | 87491 | CHLAMYDIA DNA | |
| 84439 | FREE T4 | S | | | | 85300 | ANTI THROMBIN III (FUNCTIONAL) | | 87591 | GONORRHEA DNA | |
| 84436 | T4 (TOT THYROXINE) | S | GLUT | NONGEST. GLUC. TOL. (75GM) (FAST, 2HR POST) | S | | *IMMUNOLOGY TESTS* | | GCCH | GC/CHLAMYDIA DNA | |
| 84481 | FREE T3 | S | | | | ANA | ANA (ANA SCREEN NO REFLEX) | S | AFBC | AFB CULT, SITE _____ | |
| 84480 | TOTAL T3 | S | 82977 | GGT | S | ANAR | ANA with REFLEX, Pos ANA includes ENA + dsDNA | 2S | FUNG | FUNGUS CULT, SITE _____ | |
| TAB | THYROID ABS. | S | 83718 | HDL | S | | | | GENC | GENITAL CULT | |
| | *Chemistry* | | 83036 | HEMOGLOBIN A1C | L | HAB | HEPATITIS A ANTIBODY IgM | S | HERPC | HERPES CULT, SITE _____ | |
| 82040 | ALBUMIN | S | 83540 | IRON | S | 86706 | HEP B SURF AB | S | RAPA | RAPID STREP A SCN, THROAT | |
| 84075 | ALK PHOSPHATASE | S | IIBC | IRON, IBC, & IRON SAT. | S | 87340 | HEP B SURF AG | S | RESP | ROUTINE CULTURE, SITE _____ | |

**A Clinic code, clinic location and name, and provider MUST be listed at the top if using this form.**

1. **Clinic code:** Required. Write in clinic code; appears at the top left hand corner of EPIC Lab Order Summary above barcode. Can contact Lab if you do not know your clinic code.
2. **AH:** Required. List clinic name and location (eg. Bergan Dermatology)
3. **P:** List clinic phone number.
4. **F:** List clinic fax number.
5. **HCP:** Required. Ordering Health Care Provider; List first and Last Name of provider.
6. **SHCP:** Secondary health care provider

# EPIC Downtime Lab Orders

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7. All patient information must be filled out completely.
    a. **Name:** Required. Must have patient's full legal name; First Name, Middle Initial (if provided) and Last Name.
    b. **Sex:** Required. Designate Male or Female
    c. **DOB:** Required. Patient's Date of Birth in Format (MM/DD/YYYY)
    d. **SSN:** If available, needed for correct identification.
    e. **MRN#:** Medical Record Number
    **f. Enctr#:** List the Epic encounter number.
    **g. GUAR:** Guarantor information from patient's insurance.
    **h. SEX:** Gaurantor's sex
    **i. DOB:** Gaurantor's Date of birth in Format (MM/DD/YYYY)
    **j. EMPLR:** Employer of Gaurantor
    **k. ADDR:** Address of patient
    **l. PH:** Patient's Phone number
    **m. INS:** Name of Primary Insurance
        **i. ADDR:** Address of Payer
        **ii. ID:** Subscriber ID # for insurance
        **iii. GRP#:** Group number for insurance
        **iv. GRP Name:** Group name of Insurance
8. **Make a Copy of patient's insurance card and attach to requisition to send to Lab.**
9. **Date Collected:** Required. Acceptable format is Month, Day, Year
10. **Time Collected:** Required. Use Military time (ie 0900, 1400) or conventional time (ie 9:00am/2 pm)
11. **Collected By:** Required. Print first initial and full last name (ie S. Jones)
12. **ICD10:** Acceptable format is alphanumeric coded diagnosis. Narrative or descriptive codes will not be accepted.
13. **Call/Fax:** If lab results are to be called or faxed, mark the appropriate box at the top right corner, name of fax recipient, and secure fax number.
14. **Bill to:** Required. Bill Type must be identified. Mark the appropriate box: Bill to Office Account or Bill to Patient/Insurance. If Bill to Patient/Insurance, insurance information MUST be filled out on form or a demographic sheet attached.
        iv. A copy of the front and back of the insurance card is required.
15. **Medicare Limited Coverage Tests.** Refer to your NCD/LCD Covered Codes available online on Lab website for diagnoses codes that meet compliance. If none of the codes are acceptable, an ABN (Advanced Beneficiary Notice) waiver must accompany the requisition. The ABN must be signed by the patient PRIOR to the service being performed. Please acknowledge whether a waiver has been signed and attached to the requisition.
        i. Keep a copy of the ABN at the clinic to scan into EPIC.

16. **Tests:** Listed are the most common tests with the CPT codes for CHI Health Lab. The AMA (American Medical Association) approved panels are listed first on the left hand side of the requisition. All other tests are listed under the subtopics of THYRIOD TESTING, CHEMISTRY, DRUG LEVELS, HEMATOLOGY, IMMUNOLOGY TESTS, URINE TESTING, OB/GYN, AND MICROBIOLOGY TESTING.
17. **Marking Tests:** Mark the box to the left of the test name and keep within the boundary of the box. Testing could be delayed if clarification is needed for testing ordered.
    a. **Tube Code:** On the right hand side of the test box, across from the test name the tube type is indicated with a letter. See Key explaining abbreviations at the bottom right of the requisition.
    b. **Additional Information**: When appropriate, complete any additional prompts for information. Examples are drug level dosage, total urine volumes, patient height and weight with appropriate units, and antibiotic information.
    c. **Unlisted Tests**: Use the blank space at the bottom right under Additional tests to write in any testing requested that is not listed. Provide a complete description of the requested test. No Abbreviations. Utilize online Lab test directory for correct name.
18. **Online Lab User's Guide**: Refer to the web page www.CHIhealth.com/laboratory for instructions on proper handling of specimens including tube types, specimen processing, "order of draw" and transport temperature.
19. **Specimen Labeling:** All Specimens are **required** to be labeled with: Patient's Last Name, Patient's First Name, Date of Birth, Collection Date and Time, and initials of collector.
    a. Always label specimens in the presence of the patient.
    b. Bar-coded labels will not print if EPIC is unable to send orders to Cerner (lab IT system).
    c. If submitting any molecular or microbiology specimens, include the source of the specimen.
20. Make a copy of this form.
    a. Send the original in the biohazard bag with the specimen to lab.
    b. Keep the copy at the clinic to monitor for results.
        i. If EPIC is down, results may not interface and you may need to check on these and obtain a faxed copy of the result that you can scan into EPIC.