Orders

Children's of Alabama

COA Office Use Only
Patient Label

Referred Testing Order Form
Patient and physician instructions on back of form

Patient Name:_____ Patient Date of Birth:_____ Patient Home Phone:_____
Current Height:_____Current Weight:_____ Allergies:_____
Date of Scheduled Test/Procedure (If Known):__Time be Scheduled Test/Procedure (If Known): _____

Written Diagnosis and/or Reason for Test **(Required):** *ICD-10 code, "R/O", or "Evaluate for" are not acceptable*

_____

Patient's Current Medications **(Required** for lab cultures and drug levels) Name, Dosage, and Frequency:

_____

Physician's/Prescriber Signature (R**equired):**_____Date(**Required**):_____Time**:**_____
Printed Physician's/Prescriber name **(Required):**_____Office Number (**Required):**_____

LABORATORY

DOES THE PATIENT HAVE A PORT THAT YOU REQUEST USED FOR BLOOD DRAW? **YES** OR **NO**. IF **YES**, please include order for heparin.

Heparin LOOK ALIKE/SOUND ALIKE	Calculate Dose	Route	Infusion Instructions
Heparin Flush (TEN) 10 units/mL	1 mL (10 units)	IV	PRN for flush after each use daily
Heparin Flush (HUNDRED) 100units/mL	3 mLs (300 units)	IV	ONCE prior to de-accessing port

___Activated Partial Thromboplastin Time
___Anti-Thrombin III
___Anti-XA Level
___Bilirubin Level Fractioned
___Bilirubin Level Fractioned Neonatal Less than 30 days
___Complete Blood Count for Cytopenias with Automated Differential
___ Complete Blood Count for Cytopenias with Manual Differential
___ Complete Blood Count No Differential
___ Complete Blood Count with Automated Differential
___ Complete Blood Count with Manual Differential
___Comprehensive Metabolic Panel
___Comprehensive Metabolic Panel Less than 30 Days Old
___Cystic Fibrosis Culture
___Fluid Balance Panel

*For questions, please call 205-638-9612

___ECG/EKG Routine (If follow up post-Covid, date of positive test:_____

___Glucose Tolerance Test (MUST BE SCHEDULED, call 205-638-9141)
___Hemoglobin S Quantitative
___Lead
___Liver Function Panel
___Pregnancy Test Urine
___Prothrombin Time (PT)-INR Study
___Prothrombin Time and Activate Partial Thromboplastin Time (PT/PTT)
___Renal Function Panel
___Sickle Cell Screen
___Stool Culture
___Sweat Test (MUST BE SCHEDULED, call 205-638-9141)
___Urine Culture Clean Catch
___Urinalysis
OTHER/MISCELLANEOUS TESTS (PLEASE SPECIFY EXACT TEST NAME LEGIBLY PRINT): _____
_____
_____

___EEG:_____□Routine □1 hour □Ambulatory_____
Schedule: Call 205-638-9291 FAX ORDER 205-638-5383

SLEEP STUDY_____
Schedule: Call 205-638-9386 FAX ORDER to 638-2466. Sleep history form must be sent prior to scheduling. See back of form for additional instructions.

GI LAB: (Specify Procedure)_____
Schedule: Call 205-638-9020 FAX ORDER 205-638-2075

IMAGING

(Indicate location, site, and with or without contrast. For questions call (205-638-9730)

___**X-ray**:_____
● No scheduling required ●Fax Order 205-638-5383 (Downtown)
● Fax Order 205-638-4803 (South)

___**Fluoroscopy**:_____
●Schedule205-638-2378 ●Fax Order 205-638-5383 (Downtown)
●Schedule205-638-2378 ●Fax Order 205-638-4803 (South)

___**Ultrasound**_____
●Schedule205-638-2378 ●Fax Order 205-638-5383 (Downtown)
●Schedule205-638-2378 ●Fax Order 205-638-4803 (South)

___**DEXA**:_____
●Schedule205-638-9667 ●Fax Order 205-638-5383 (Downtown)

___**Nuclear Medicine**:_____
●Schedule 205-638-9667 ●Fax Order 205-638-5383 (Downtown)

___**Other**:_____
●Schedule 205-638-2378 ●Fax Order 205-638-5383

___**CT**:_____
● Schedule without GA or Sedation 205-638-2378 ●Fax Order 205-638-5383
With GA:_____(Downtown) With Sedation:_____(South)
●Schedule 205-638-2378 ●Schedule 205-638-2378
●Fax Order 205-638-3150 ●Fax Order 205-638-4803
PreCert Number (**Required**):_____
PreCert Expiration Date (**Required**):_____

___**MRI**:_____
● Schedule without GA or Sedation 205-638-2378 ●Fax Order 205-638-5383
With GA:_____(Downtown) With Sedation:_____(South)
●Schedule 205-638-2378 ●Schedule 205-638-2378
●Fax Order 205-638-3150 ●Fax Order 205-638-4803
PreCert Number (**Required**):_____
PreCert Expiration Date (**Required**):_____

___**PET**:_____
● Call PET to schedule 205-638-3133 ●Fax Order 205-638-5383
With GA:_____(Downtown Only)
● Schedule 205-638-9777 PreCert Number (**Required**):_____
● Fax Order 205-638-5292 PreCert Expiration Date (**Required**):_____

***Please Fax Order and provide the patient a copy of the order to bring to their visit**

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PHYSICIAN INSTRUCTIONS/INFORMATION

SLEEP DISORDERS

The referring physician must do the following:

- Fax a Polysomnogram Request form to 205-638-2466
- If you do not have a form, the form can be downloaded from the COA SDC webpage https://www.childrensal.org/sleep-disorders-healthcare-professionals or call 205-638-9386 for a form to be faxed.
- Fax clinic notes, patient history, demographic sheet and insurance information
- If the patient has Medicaid, fax a referral form with a valid EPSDT screening date.
- If the patient has Tricare or Viva, fax referral from PCP.

Once all of the information is received, a Sleep Study or Sleep Clinic appointment will be faxed within 24 hours to the referring physician's office.

The patient will be mailed a Sleep Packet after the appointment is made.

LABORATORY PANELS CONSIST OF THE FOLLOWING

- Comprehensive Metabolic Panel (Na; K; Cl; CO2; Anion Gap; Glucose, BUN, Creatinine; Calcium; TotalProtein; Albumin; AST; ALT; Alkaline Phosphate; Total Bilirubin)
- Fluid Balance Panel (Sodium, Potassium, Chloride, CO2, Anion Gap; Glucose, BUN, Creatinine, Calcium)
- Lipid Panel (Cholesterol; Triglycerides; HDL; LDL; Cholesterol/HDL ratio)
- Liver Function Panel (Albumin, Alkaline Phosphatase, Direct, Indirect and Total Bilirubin; AST; ALT; Total Protein)
- Electrolyte Panel (Na; K; Cl; CO2; Anion Gap)
- Renal Function Panel (Na; K; Cl; CO2; Anion Gap; Glucose, BUN, Creatinine; Calcium; Albumin; Phosphorous)
- Hepatitis Panel (Hepatitis B Surface Antigen; Hepatitis B Core IgM Antibody; Hepatitis A IgM Antibody; Hepatitis C Antibody)

INFORMATION FOR PATIENTS/PARENTS FOR LABORATORY SERVICES

For parents instructed by physician to go to the Children's downtown Campus for laboratory services, the patient must be registered first.

Weekday Daytime Hours

Please go to Referred Testing Registration located on the 2nd Floor, McWane Building (7th Avenue South)

- Monday – Thursday: 6:00 am – 6:00 pm (open until 7:30pm for Sleep Studies and Radiology Testing)
- Friday: 6:00 am – 5:00 pm

Weekday After Hours

Please go to Admitting located on the 2nd Floor, Benjamin Russell Hospital for Children (5th Avenue South) for Registration

- Monday – Thursday: 6:00 pm – Midnight
- Friday: 5:00 pm to Midnight

Weekends

Please go to Admitting located on the 2nd Floor, Benjamin Russell Hospital for Children (5th Avenue South) for Registration

- Saturday & Sunday: 8:00 am – Midnight