Name of Practice

Address Line 1
Address Line 2
Phone: __________

Please Fax Results To: ___________

☐ **Doctor #1**
☐ **Doctor #2**
☐ **Doctor #3** Physician's Signature: ______________________________ Date: _________________

Outpatient Laboratory Request

PATIENT INFORMATION:
Name:
Phone:
Patient Insurance:

DIAGNOSIS/REASON FOR TESTING:

☐	CBC WITH DIFFERENTIAL
☐	ANGIOTENSIN CONVERTING ENZYME
☐	SERUM LYSOZYME
☐	ANTI-NUCLEAR ANTIBODIES
☐	Anti-dsDNA
☐	Anti-SS-A (La)
☐	Anti-SS-B (Ro)
☐	Extractable Nuclear Antigen (ENA) Panel
☐	RHEUMATOID FACTOR
☐	CCP ANTIBODY
☐	FTA-ABS
☐	TP-PA
☐	RPR
☐	TREPONEMAL PALLIDUM EIA
☐	ANCA by ELISA (Proteinase-3, Myeloperoxidase)
☐	HLA A29
☐	HLA B51
☐	HLA B27
☐	HLA DR2
☐	CMV, HSV, HZV IgG + IgM
☐	LYME TITERS (IFA + ELISA)
☐	LYME WESTERN BLOT
☐	BARTONELLA HENSELAE IgG + IgM
☐	BARTONELLA QUINTANA IgG + IgM
☐	QUANTIFERON GOLD
☐	TOXOCARA TITERS IgG + IgM
☐	TOXOPLASMOSIS TITERS IgG + IgM

☐	ERYTHROCYTE SEDIMENTATION RATE
☐	C-REACTIVE PROTEIN
☐	***STAT CALL WITH RESULTS: ____________***

☐	ANTICARDIOLIPIN ANTIBODIES
☐	LUPUS ANTICOAGULANT
☐	PROTEIN S LEVELS
☐	PROTEIN C LEVELS
☐	HOMOCYSTEINE LEVELS (SERUM & URINE)
☐	FACTOR V LEIDEN
☐	ANTI-THROMBIN III

☐	FASTING BLOOD GLUCOSE
☐	TOTAL CHOLESTEROL
☐	TRIGLYCERIDES
☐	URIC ACID
☐	ACETYLCHOLINE RECEPTOR ANTIBODIES Binding, Blocking, Modulating
☐	TSH
☐	TSI
☐	T4, T3

☐	CHEST X-RAY (AP/PA) R/O SARCOIDOSIS
☐	PPD (R ARM)

☐	