NATIONWIDE CHILDREN'S

Laboratory Services
700 Children's Drive, Columbus, Ohio, 43205
P: (614) 722-5477 / (800) 934-6575
NationwideChildrens.org/Lab

Riverside Methodist
Hospital-Laboratory
3535 Olentangy River Rd
Laboratory
Columbus, OH 43214
P: 614-566-3715 / F: 614-566-6982

Please Mark Billing Option:
Patient Bill _____ Z052 / Client Bill _____ RIV

LEAD REQUISITION

ALL BOLDED INFORMATION IS REQUIRED BY LAW FOR LEAD TESTING IF NOT PROVIDED, TESTING WILL NOT BE PERFORMED

Patient Information		
Last Name:	**First Name:**	**MI:**
MRN/ Patient ID #:	**DOB:**	**Sex: [ ] Male [ ] Female [ ] Unknown**
Address:		
City, State, Zip:		
County: [ ] Franklin [ ] Delaware [ ] Fairfield [ ] Licking [ ] Madison [ ] Muskingum [ ] Pickaway [ ] Other: ______		
Phone #: ( )	**Social Security #:**	
Race: [ ] African (E) [ ] American Indian/Alaska Native (I) [ ] Asian (A) [ ] Bi-racial/Multi-racial/Other (O)	[ ] Black/ African American (B) [ ] Latino/Hispanic/Black (K) [ ] Latino/Hispanic/Unspecified (N) [ ] Latino/Hispanic/White (L)	[ ] Native Hawaiian / Pacific Islander (P) [ ] White/Caucasian (W) [ ] Patient/Family Declined (D) [ ] Unavailable/ Unknown (U)
Ethnicity: [ ] Hispanic [ ] Non-hispanic [ ] Other [ ] Unknown		

Patient Employer Name (if patient >16 years):
Employer Address:
City, State, Zip:

Parent/Guardian / Billing Information		
Legal Guardian Last Name:	**First Name:**	**MI:**
Patient Relationship:	**Contact Phone #: ( )**	
Subscriber Last Name:	First Name:	MI:
Subscriber DOB:	Sex: [ ] Male [ ] Female	
Subscriber Phone #:		
Subscriber Address (if different from patient):		
City, State, Zip:		
Insurance Co. Name:	Policy #:	Group#:
Insurance Address:		
City, State, Zip:		
Secondary Insurance Co. Name:	**Medicaid # (if any):**	

Specimen Information		
Collection Date: Time: [ ] AM [ ] PM Collected By: (Full Name)	[ ] LEAD [ ] Capillary Filter Paper (PBFP) [ ] Capillary Microtainer (PBO) [ ] Venipuncture (PBO)	[ ] HEMOGLOBIN [ ] Capillary Filter Paper (HGBFPB) [ ] Capillary Microtainer (HGB) [ ] Venipuncture (HGB)

Physician Information	
Physician Address (if different from above address):	
City, State, Zip:	**NPI #:**

Diagnosis/ ICD 10 ________________ Physician (Print full name) ______________________ Physician's Signature (Required) _________________________

Date ____________ Time ___________