Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

HEAVY METAL REQUISITION DEMOGRAPHICS FORM

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | County | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

THE STATE OF OHIO REQUIRES THE FOLLOWING INFORMATION WHEN ORDERING LEAD, CADMIUM, MERCURY OR ARSENIC

ETHNICITY: ☐ Unknown (;Z) ☐ Hispanic (;H) ☐ Non-Hispanic (;N) ☐ Other (;O)

RACE: ☐ Unknown (;Z) ☐ White (;W) ☐ Black (;B) ☐ Asian (;A) ☐ Native American (;N)

Name of guardian/parent (if patient is under 16 years of age)

PLEASE COMPLETE THE FOLLOWING SECTION WHEN A COPY OF INSURANCE CARD (FRONT AND BACK) IS NOT PROVIDED.

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

WORKER'S COMPENSATION

Claim# | Date of Injury

BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)

BILL TO: ☐ Client ☐ Patient ☐ Medicare ☐ Other Insurance

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes

1. _____ 2. _____ 3. _____

CLIENT INFORMATION

SAMPLE INFORMATION (REQUIRED)

Collection Date: ____/____/____ Time: _____

Collected by: _____

Specimen Type:

☐ Venous Blood (;V) or ☐ Capillary Blood (;C)

☐ Random Urine or ☐ 24 hours/volume _____ml

PHYSICIAN INFORMATION (REQUIRED)

Physician Signature

Date / Time

Physician Name (please print)

Address

City, State, Zip

Phone | UPIN

☐ Send additional report

Physician: _____

Address: _____

City, State, Zip: _____

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

EMPLOYER INFORMATION (REQUIRED)

Patient's Employer (or ;NA)

Address (or ;NA)

City (or ;NA), State (or ;NA), Zip (or ;NA)

MEDICAL NECESSITY NOTICE

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INDICATE TESTS REQUESTED

- ☐ Arsenic, Blood *ASB*
- ☐ Arsenic, Fractionated Urine *UASFR*
- ☐ Arsenic, Hair *ARSHR*
- ☐ Arsenic, Urine 24 Hr *UARSND*
- ☐ Cadmium, Blood *CADMWB*
- ☐ Cadmium Exposure Panel, OSHA *CADEXR*
- ☐ Cadmium, Urine *URCAD*
- ☐ Heavy Metals Screen, Whole Blood *HEVMET*
- ☐ Heavy Metals, Urine *UTXM3*
- ☐ Heavy Metals with Cadmium, Ur *UTXM4*
- ☐ Heavy Metals with Cadmium, Whole Blood *HEVMT4*
- ☐ Lead, Blood *LEAD2*
- ☐ Lead, Urine 24 Hour *ULEADQ*
- ☐ Mercury, Blood *MERC2*
- ☐ Mercury, Urine 24 Hour *UMERC3*

Ohio Administrative Codes 3701-30-05 and 3701-32-14 state that any physician or healthcare provider requesting analysis for lead, cadmium, arsenic or mercury shall complete each request with the above information.

<<FORM_ID>>