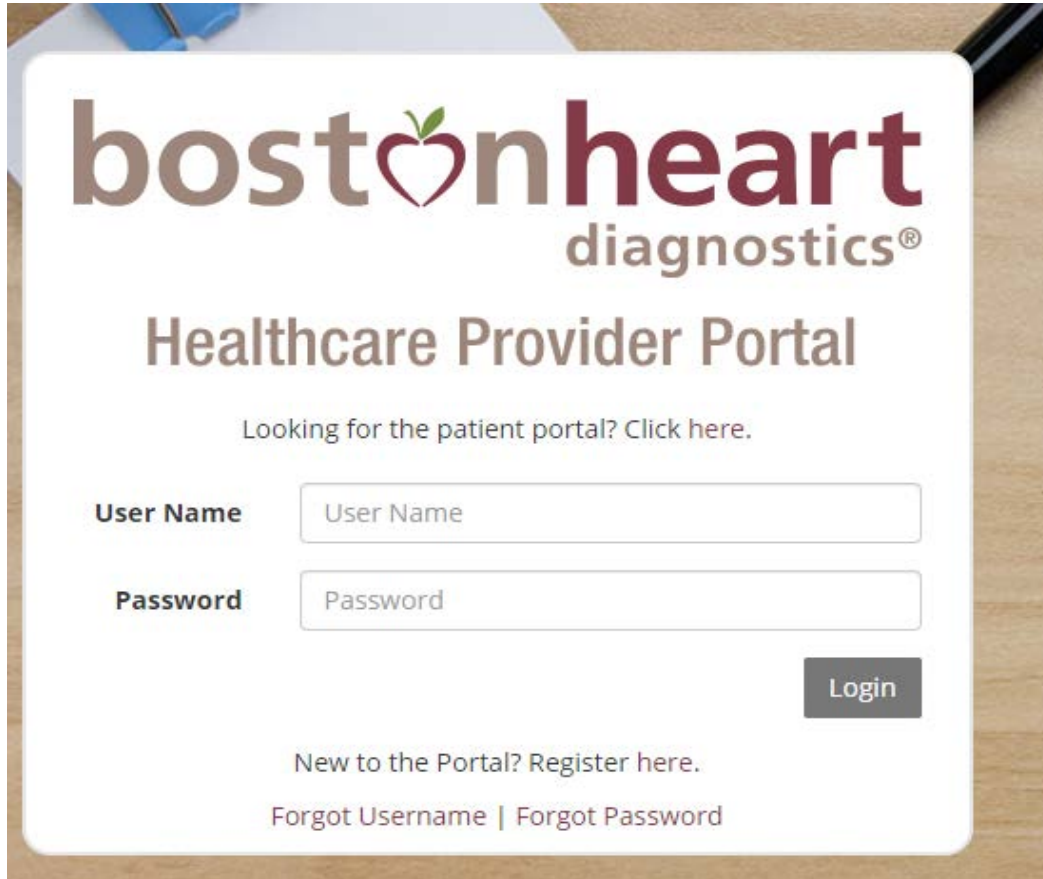


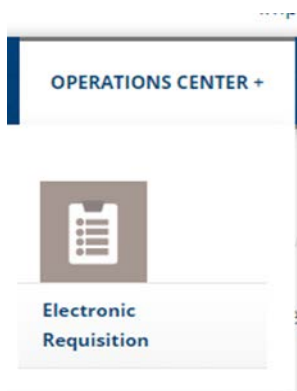


How To Use and Save A Boston Heart Fillable Req

Step 1: Login into your Account



Step 2: Click on the Operations Center



Step 3: Click on E REQS: this is not an ereq, only one you can type in and print

home > electronic requisition > electronic requisition orders

Electronic Requisition

Use the links below to preview your electronic requisitions.



Step 4: Click on the PDF E REQ- that is a req you can type on only, you can't order from inside here

<p>bostonheart diagnostics®</p>		<p>3RD PARTY REQUISITION</p>		<p>p) 877.425.1252 f) 508.663.5484 bostonheartdiagnostics.com</p>	
<p>Client #: 1234</p>		<p>Draw guide provided with kit</p>			
<p>Boston Heart 123 Diagnostic Blvd Boston, MA 12345</p>		<p>Collection Date: _____ Collection Time: _____</p>			
<p>Ordering Provider: _____</p>		<p>Phlebotomist ID: _____ *Fasting at least 8 hrs? <input type="checkbox"/> Y or <input type="checkbox"/> N</p>			
<p>Other Ordering Provider: _____</p>		<p>TEST MENU See reverse for panel components and additional test codes</p>			
<p>By submission of this requisition/sample(s), I: (i) authorize/direct BHD to perform tests indicated below; (ii) certify that each ordered test is reasonable/medically necessary for diagnosis/treatment of patient's current condition; (iii) certify that I'm in compliance with all applicable state laws and I obtained patient's written informed consent to undergo genetic tests (results should be reported to me); (iv) agree to provide BHD with copy of patient's signed/initialized consent upon request; (v) acknowledge that each genetic test is performed once in patient's lifetime and (vi) that diagnosis codes are indicated to highest level of specificity.</p>		<p>Tests require 2 Tiger Top tubes unless noted: <input type="checkbox"/> Pearl <input type="checkbox"/> Lavender <input type="checkbox"/> Red/Yel CAT <input type="checkbox"/> Yellow Top Urine</p>			
<p>Authorized Provider Signature _____ Date _____</p>		<p>*Fasting strongly recommended <input type="checkbox"/> Boston Heart Exclusive Test <input type="checkbox"/></p>			
<p>PATIENT INFORMATION</p>		<p>LIPIDS</p>			
<p>DOB: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F MRN: _____</p>		<p>809 <input type="checkbox"/> HDL Map (particles only) <input type="checkbox"/> <input type="checkbox"/> 430 <input type="checkbox"/> Albumin/Creatinine Ratio, Random Urine <input type="checkbox"/></p>			
<p>LAST NAME: _____ FIRST NAME: _____ MI: _____</p>		<p>575 <input type="checkbox"/> Fatty Acid Balance <input type="checkbox"/> <input type="checkbox"/> * 1003 <input type="checkbox"/> ALT (SGPT)</p>			
<p>CELL PHONE: _____</p>		<p>200B <input type="checkbox"/> Lipid Panel, Basic 1002 <input type="checkbox"/> AST (SGOT)</p>			
<p>EMAIL: _____</p>		<p>101 <input type="checkbox"/> Total Cholesterol (TC) 607 <input type="checkbox"/> B12</p>			
<p>STREET: _____</p>		<p>102 <input type="checkbox"/> Triglycerides (TG) 725 <input type="checkbox"/> CBC <input type="checkbox"/></p>			
<p>CITY: _____ ST: _____ ZIP: _____</p>		<p>221 <input type="checkbox"/> HDL-Cholesterol (HDL-C) 720 <input type="checkbox"/> CBC with differential <input type="checkbox"/></p>			
<p>Systolic/Diastolic BP: _____ / _____ Height: _____ ft _____ in Weight (lbs): _____</p>		<p>222 <input type="checkbox"/> Direct LDL-Cholesterol (LDL-C) 606 <input type="checkbox"/> CoQ10 *</p>			
<p>Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Other</p>		<p>223 <input type="checkbox"/> sdLDL-Cholesterol (sdLDL-C) 1001 <input type="checkbox"/> Creatine Kinase (CK)</p>			
<p>Patient History: <input type="checkbox"/> CVD <input type="checkbox"/> Family Hx of CVD <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Parental Hx of Diabetes <input type="checkbox"/> Current Smoker <input type="checkbox"/> None of the above</p>		<p>301 <input type="checkbox"/> Apolipoprotein A-I (ApoA-I) 1007 <input type="checkbox"/> Creatinine</p>			
<p>Medications: <input type="checkbox"/> Statin <input type="checkbox"/> Fibrate <input type="checkbox"/> Ezetimibe <input type="checkbox"/> Niacin <input type="checkbox"/> PCSK9 Inhibitors <input type="checkbox"/> BP Medication <input type="checkbox"/> Insulin <input type="checkbox"/> Fish Oil/Omega-3 <input type="checkbox"/> None of the above</p>		<p>302 <input type="checkbox"/> Apolipoprotein B (ApoB) 1045 <input type="checkbox"/> Ferritin</p>			
<p>BILLING Check all payment methods that apply to this order</p>		<p>224 <input type="checkbox"/> Lp(a) 610 <input type="checkbox"/> Folate</p>			
<p><input type="checkbox"/> Insurance: Attach copy (front & back) of card or demographic sheet</p>		<p>98006 <input type="checkbox"/> LDL-P & HDL-P by NMR <input type="checkbox"/> * AC751 <input type="checkbox"/> Lifestyle Panel <input type="checkbox"/> <input type="checkbox"/> & 1 Tiger Top SST</p>			
<p><input type="checkbox"/> Medicare/Gov Payor: _____</p>		<p>METABOLIC</p>			
<p><input type="checkbox"/> Client bill</p>		<p>420 <input type="checkbox"/> Prediabetes Assessment, Reflex <input type="checkbox"/> * 404 <input type="checkbox"/> Hemoglobin A1c (HbA1c) <input type="checkbox"/></p>			
<p>Patient Pay: indicate payment method & sign below</p>		<p>408C <input type="checkbox"/> HOMA-IR w/ Beta Cell Function <input type="checkbox"/> * 408 <input type="checkbox"/> HOMA-IR *</p>			
<p><input type="checkbox"/> Check/Credit Card Form attached <input type="checkbox"/> Invoice via email <input type="checkbox"/> Invoice via text</p>		<p>401 <input type="checkbox"/> Glucose 895 <input type="checkbox"/> RT-PCR (NP swab)</p>			
<p>Boston Heart (BH) may bill my insurer and I irrevocably assign to BH my right to payment. BH may appeal claim denials and obtain my medical/billing information to facilitate payment. I agree to remit payment to BH if I am paid directly by my insurer and I will pay for any deductibles, co-insurance, co-pays, or denied services. BH may refer me to a collection agency for non-payment. BH may communicate with me via email/text regarding services and payment if I provide my email/phone number. I understand that HIPAA gives me the right to request communication by alternate means.</p>		<p>402 <input type="checkbox"/> Insulin 896 <input type="checkbox"/> RT-PCR (Nasal swab)</p>			
<p>Patient Signature: _____ Date: _____</p>		<p>410 <input type="checkbox"/> C-peptide 641 <input type="checkbox"/> SARS-CoV-2 IgM (serum)</p>			
<p>ICD-10 Commonly used codes listed for convenience. Report all reasons for ordering test(s).</p>		<p>409 <input type="checkbox"/> Glycated Serum Protein (GSP) 649 <input type="checkbox"/> Neutralizing Antibody (serum)</p>			
<p>E11.9 <input type="checkbox"/> Type 2 diabetes mellitus w/o complications I73.03 <input type="checkbox"/> Peripheral vascular disease, unspecified E11.65 <input type="checkbox"/> Type 2 diabetes mellitus w/ hyperglycemia R73.03 <input type="checkbox"/> Prediabetes</p>		<p>407 <input type="checkbox"/> Adiponectin 648 <input type="checkbox"/> Spike Antibody (serum)</p>			
		<p>1191 <input type="checkbox"/> IL-6 (w/ CVD reference ranges) 1190 <input type="checkbox"/> IL-6 (COVID-19 use only)</p>			
		<p>635 <input type="checkbox"/> OxPL-apoB</p>			
		<p>INFLAMMATION & OXIDATION</p>			
		<p>601 <input type="checkbox"/> hs-CRP</p>			
		<p>602 <input type="checkbox"/> LpPLA2</p>			
		<p>604 <input type="checkbox"/> Myeloperoxidase (MPO) <input type="checkbox"/></p>			
		<p>701 <input type="checkbox"/> Fibrinogen <input type="checkbox"/></p>			
		<p>1129 <input type="checkbox"/> IL-6 (w/ CVD reference ranges)</p>			
		<p>635 <input type="checkbox"/> OxPL-apoB</p>			
		<p>HORMONES (Immunoassay)</p>			
		<p>1134 <input type="checkbox"/> DHEA Sulfate (DHEA-S)</p>			
		<p>1128 <input type="checkbox"/> Estradiol (E2)</p>			
		<p>1122 <input type="checkbox"/> FSH</p>			
		<p>1120 <input type="checkbox"/> LH</p>			
		<p>1124 <input type="checkbox"/> Progesterone</p>			
		<p>1130 <input type="checkbox"/> SHBG</p>			
		<p>1127 <input type="checkbox"/> Testosterone, Free (calculated, includes: Alb, SHBG, Total Testosterone)</p>			
		<p>1126 <input type="checkbox"/> Testosterone, Total</p>			
		<p>1112 <input type="checkbox"/> PSA, Total</p>			
		<p>1112R <input type="checkbox"/> w/ Reflex to PSA, Free</p>			
		<p>4429 <input type="checkbox"/> Cortisol</p>			
		<p>ADDITIONAL TESTS (See reverse for directory)</p>			
		<p>895 <input type="checkbox"/> RT-PCR (NP swab)</p>			
		<p>896 <input type="checkbox"/> RT-PCR (Nasal swab)</p>			
		<p>641 <input type="checkbox"/> SARS-CoV-2 IgM (serum)</p>			
		<p>649 <input type="checkbox"/> Neutralizing Antibody (serum)</p>			
		<p>648 <input type="checkbox"/> Spike Antibody (serum)</p>			
		<p>1190 <input type="checkbox"/> IL-6 (COVID-19 use only)</p>			
		<p>PATIENT PAY ONLY Signature required in Billing section. Medicare patients must submit ABN.</p>			
		<p>GENETICS <input type="checkbox"/> or buccal swab</p>			
		<p>806 <input type="checkbox"/> Apolipoprotein E CVD/dementia risk</p>			
		<p>816 <input type="checkbox"/> Factor V Leiden Clot formation</p>			
		<p>826 <input type="checkbox"/> Factor II Clot formation</p>			
		<p>830 <input type="checkbox"/> CYP2C19 PLAVIX® response</p>			
		<p>835 <input type="checkbox"/> SLC01B1 Statin-induced myopathy <input type="checkbox"/></p>			

Step 5: Fill out tests you wish to run for patient

3RD PARTY REQUISITION

Client #: 1234

Boston Heart
123 Diagnostic Blvd
Boston, MA 12345

Ordering Provider: -- Other --

Other Ordering Provider:

By submission of this requisition/sample(s), I: (i) authorize/direct BHD to perform tests indicated below; (ii) certify that each ordered test is reasonable/medically necessary for diagnosis/treatment of patient's current condition; (iii) certify that I'm in compliance with all applicable state laws and I obtained patient's written informed consent to undergo genetic tests (results should be reported to me); (iv) agree to provide BHD with copy of patient's signed/dated consent upon request; (v) acknowledge that each genetic test is performed once in patient's lifetime and (vi) that diagnosis codes are indicated to highest level of specificity.

Authorized Provider Signature: _____ Date: _____

PATIENT INFORMATION

DOB: 08/14/1956 Sex: M F MRN: _____

LAST NAME: Smith FIRST NAME: Richard MI: _____

CELL PHONE: _____

EMAIL: _____

STREET: _____

CITY: _____ ST: _____ ZIP: _____

Systolic/Diastolic BP: _____ / _____ Height: _____ ft _____ in Weight: _____ lbs

p) 877.425.1252 f) 508.663.5484
bostonheartdiagnostics.com

SPECIMEN Draw guide provided with kit

Collection Date: 08/08/2021 Collection Time: 9am

Phlebotomist ID: _____ *Fasting at least 8 hrs? Y or N

TEST MENU See reverse for panel components and additional test codes

Tests require 2 Tiger Top tubes unless noted: Pearl Lavender Red/Yel CAT Yellow Top Urine

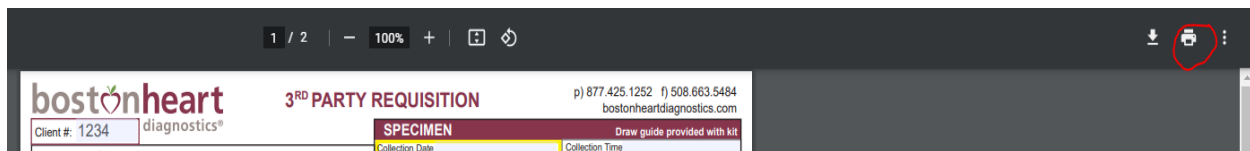
*Fasting strongly recommended Boston Heart Exclusive Test

<p>LIPIDS</p> <p>809 <input type="checkbox"/> HDL Map (particles only) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>509 <input type="checkbox"/> Cholesterol Balance (sterols only) <input type="checkbox"/></p> <p>575 <input type="checkbox"/> Fatty Acid Balance <input type="checkbox"/> <input type="checkbox"/> *</p> <p>200B <input type="checkbox"/> Lipid Panel, Basic</p> <p>101 <input type="checkbox"/> Total Cholesterol (TC)</p> <p>102 <input type="checkbox"/> Triglycerides (TG)</p> <p>221 <input type="checkbox"/> HDL-Cholesterol (HDL-C)</p> <p>222 <input type="checkbox"/> Direct LDL-Cholesterol (LDL-C)</p> <p>223 <input type="checkbox"/> sdLDL-Cholesterol (sdLDL-C)</p> <p>301 <input type="checkbox"/> Apolipoprotein A-I (ApoA-I)</p> <p>302 <input type="checkbox"/> Apolipoprotein B (ApoB)</p> <p>224 <input type="checkbox"/> Lp(a)</p> <p>98006 <input type="checkbox"/> LDL-P & HDL-P by NMR <input type="checkbox"/> *</p> <p>AC751 <input type="checkbox"/> Lifestyle Panel <input type="checkbox"/> <input type="checkbox"/> & 1 Tiger Top SST</p> <p>METABOLIC</p> <p>420 <input type="checkbox"/> Prediabetes Assessment, Reflex <input type="checkbox"/> *</p> <p>404 <input type="checkbox"/> Hemoglobin A1c (HbA1c) <input type="checkbox"/></p> <p>408C <input type="checkbox"/> HOMA-IR w/ Beta Cell Function <input type="checkbox"/> *</p> <p>408 <input type="checkbox"/> HOMA-IR *</p> <p>401 <input type="checkbox"/> Glucose</p> <p>402 <input type="checkbox"/> Insulin</p>	<p>OTHER</p> <p>430 <input type="checkbox"/> Albumin/Creatinine Ratio, Random Urine <input type="checkbox"/></p> <p>1003 <input type="checkbox"/> ALT (SGPT)</p> <p>1002 <input type="checkbox"/> AST (SGOT)</p> <p>607 <input type="checkbox"/> B12</p> <p>725 <input type="checkbox"/> CBC <input type="checkbox"/></p> <p>720 <input type="checkbox"/> CBC with differential <input type="checkbox"/></p> <p>606 <input type="checkbox"/> CoQ10 *</p> <p>1001 <input type="checkbox"/> Creatine Kinase (CK)</p> <p>1007 <input type="checkbox"/> Creatinine</p> <p>1045 <input type="checkbox"/> Ferritin</p> <p>610 <input type="checkbox"/> Folate</p> <p>603 <input type="checkbox"/> Homocysteine (HCY)</p> <p>1040 <input type="checkbox"/> Iron</p> <p>1038 <input type="checkbox"/> Magnesium</p> <p>1009 <input type="checkbox"/> Uric Acid</p> <p>625 <input type="checkbox"/> Vitamin D (25-OH)</p> <p>SARS-CoV-2</p> <p>895 <input type="checkbox"/> RT-PCR (NP swab)</p> <p>896 <input type="checkbox"/> RT-PCR (Nasal swab)</p>
--	---

Step 6: Click the down Arrow to save PDF to computer



Step 7: Optional: You can print off the REQ now and give it to your patient



Step 8: Optional: You can email the REQ to your patient