heliosDX

HORMONE TEST REQUISITION

Ordering Physician:______________________ Name of Practice: ______________________

Date: ____/____/______ Address: ______________________

ICD Code(s)

______________________ ______________________

Ordering Physician Signature

Patient Information:

Last Name:______________ First Name:______________ MI:____ Address:______________

City:______________ State:______________ Zip Code: ______________ Phone #:______________

DOB: ____/____/______ Sex: ☐ M ☐ F ☐ Insurance:______________________ ☐ Self-Pay

*INCLUDE COPY OF INSURANCE CARD

I CERTIFY THAT I HAVE PROVIDED MY SPECIMEN TO THE COLLECTOR, THAT I HAVE NOT ADULTERATED IT IN ANY MANNER, AND THAT THE INFORMATION PROVIDED ON THIS FORM AND ON THE LABEL AFFIXED TO EACH SPECIMEN IS CORRECT. I AUTHORIZE THE RELEASE OF THE RESULTS TO THE ORDERING CLINICIAN & STAFF. I AUTHORIZE CHATTAHOOCHEE LABS TO RELEASE ANY INFORMATION REQUIRED FOR BILLING PURPOSES. I AUTHORIZE PAYMENT DIRECTLY TO CPLS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENTS SHOULD INSURANCE BE DENIED, PARTIALLY PAID OR CO-PAYMENTS REQUIRED.

Patient Signature:______________________ Date: ____/____/______

SPECIMEN INFORMATION

Date and Time of Collection: ____/____/______ ______:______ ☐ AM ☐ PM Collector Initials:__________ Fasting: ☐ Yes ☐ No

☐ **NO PRESCRIBED MEDICATIONS** ☐ **MEDICATION PRESCRIBED** (ATTACH PATIENT'S MEDICATION LIST OR LIST BELOW)

Prescribed Medication(s): ______________________

____

AVAILABLE TESTS (check all that apply)

☐ **FULL PROFILE**
(includes all testing listed below)

☐ **CORTICOSTEROID PROFILE**
- ☐ ALDOSTERONE
- ☐ CORTISOL
- ☐ CORTISONE
- ☐ CORTICOSTERONE
- ☐ 17α-OH PROGESTERONE
- ☐ 11-DEOXYCORTICOSTERONE
- ☐ 21-DEOXYCORTISOL
- ☐ 11-DEOXYCORTISOL
- ☐ PREGNENOLONE

☐ **SEX STEROID PROFILE**
- ☐ ANDROSTENEDIONE
- ☐ DHEA
- ☐ DHEA-S
- ☐ DHT
- ☐ ESTRIOL (E_3)
- ☐ ESTRONE (E_1)
- ☐ 17β-ESTRADIOL (E_2)
- ☐ PREGNENOLONE
- ☐ PROGESTERONE
- ☐ (TOTAL) TESTOSTERONE
- ☐ (FREE) TESTOSTERONE INCLUDES SHBG
- ☐ FSH
- ☐ LH
- ☐ SHBG

☐ **ADDITIONAL TESTS**
- ☐ TSH
- ☐ PSA, TOTAL (male only)
- ☐ PROLACTIN
- ☐ HGH
- ☐ INSULIN
- ☐ 25-HYDROXY VITAMIN D_3

GUIDE FOR CAPILLARY COLLECTION

Must be Red Top tube and a minimum of 600 μL of whole blood. Patient should fill above the 500 μL line. **SAMPLES MUST BE SENT OVERNIGHT ON DAY OF COLLECTION.**

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 the patient, rather than for screening purposes.

Go to our website, www.heliosdx.com, for important information regarding responsible ordering.

1122 Cambridge Square | Suite E
Alpharetta, GA 30009

T 423.206.2299
E info@heliosdx.com

Testing to be performed at CLIA# 19D2139173
800 N. Causeway Blvd., Suite 300, Mandeville, LA 70448