



IBT Laboratories
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 CLIA #17D0448989

Chronic Urticaria Test Request Form

If you would like us to work with your local laboratory to help facilitate ordering chronic urticaria, or other IBT tests, please send an email to: testing@ibtlabs.com.

<p>Chronic Urticaria Testing</p> <p>___ 2103 CU Index™ Test</p> <p>___ 403005 CU Index™ Panel</p> <p>Panel includes the following tests, each may be ordered separately:</p> <ul style="list-style-type: none"> ▪ #2103 CU Index Test ▪ #2004 Thyroid Stimulating Hormone ▪ #322 Anti-Thyroid Peroxidase IgG ▪ #2005 Anti-Thyroglobulin IgG <p><i>Since a proportion of patients with autoimmune CU also have thyroid-specific autoantibodies, testing may be indicated in some patients and may uncover an occult thyroid disorder.</i></p> <p>Other Tests Names/Codes:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Ordering Physician Information</p> <p>First Name: _____</p> <p>Last Name: _____</p> <p>Physician NPI#: _____</p> <p>Physician Phone: _____</p> <p>Physician Email*: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p><i>It is my medical judgment that the testing marked on this request form is medically necessary and the patient records in our office document the need for this testing. Tests in panels can be ordered individually.</i></p> <p>MD Name (print): _____</p> <p>_____</p> <p>Signature of Ordering Physician or Designate</p> <p>ICD-9 codes for the requested testing on this patient are the following:</p> <p>_____</p> <p>Date of Evaluation: _____</p> <p><small>* (We will not sell, distribute, or lease your personal information to third parties unless we have your permission or are required by law to do so.)</small></p>
<p>Patient Information Patient ID#: _____</p> <p>Last Name: _____ First Name: _____ MI: _____</p> <p>DOB: ___/___/___ Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M</p> <p>Specimen Draw Date ___/___/___ Draw Time: _____</p> <p>Specimen Type: Serum only <i>(Allow blood to clot prior to centrifugation; 1mL required for #2103, 3mL for #403005)</i></p>	
<p>Client/Hospital/Laboratory Billing</p> <p>Client/Hospital/Lab Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Contact Name: _____</p> <p>Phone: _____ Fax: _____</p> <p><i>(NY state law prohibits laboratories from billing NY physicians for services.)</i></p>	