NORTHERN MONTANA HEALTH CARE

NORTHERN MONTANA HOSPITAL LABORATORY ORDER FORM

30 13th St. Havre, MT 59501
Ph: 406-262-1235 Fax: 406-262-1616

Patient Name (Last, First, MI)			
Sex	**Age**	**Date of Birth**	**Patient Phone #**
Comment Section			

Provider Name	
Date	**Time**
Bill To (Please Check): o **Client:** _____ o **Patient (Include Insurance Information)**	
Diagnosis / ICD10	

Chemistry	**Chemistry**	**Urinalysis**	**Microbiology**
o CMP	o Phosphorus	o Microalbumin	o C diff. PCR
o Basic	o Potassium	o Prot/Creat Ratio	o GI Panel PCR
o Liver Panel	o PSA	o UA-Routine	o Gram stain
o Renal Panel	o Sodium	o Cult if indicated?	o Urine Culture
o Electrolytes	o T3-Free	Source: (please circle)	Source:
o Lipid	o T4-Free	CCMS Cath	
o Alcohol/ETOH	o TIBC	o Ur. Creatinine	Wound Culture
o Alk Phos	o TSH	o Ur. Protein	o Aerobic
o Ammonia	o Troponin	o Ur. Sodium	o Anaerobic
o Amylase	o Uric Acid		Source/Location:
o ALT	o Vancomycin	**Respiratory**	
o AST		o Covid 19	
o B12	**Heme / Coag**	o Influenza A/B	
o BHCG-Quant	o CBC/Diff	o RSV	
o Bilirubin-Direct	o CBC no Diff	o Rapid Strep	
o Bilirubin-Total	o Retic	o Resp. Panel PCR	
o BUN	o Sed Rate		
o CEA	o PT/INR	**Other Tests:**	
o CK	o PTT		
o Creatinine	o D-dimer		
o CRP	o Fibrinogen		
o Digoxin			
o Ferritin	**Serology / Other**		
o Folate	o H. pylori Stl Ag		
o Gentamycin	o Mono		
o Hgb A1C	o Preg test-Serum	****Provider Signature**	
o Iron	o Preg test-Urine		
o LDH	o RPR		
o Lipase	o Rubella		
o Lithium			
o Magnesium