Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

Date: _____

NEWBORN TESTING REQUISITION - LABORATORY

Referring Institution: _____
Address: _____
Contact Person: _____
Phone# _____
Fax# _____
Referring/
Ordering MD: _____
Provider NPI: (REQUIRED) _____
NOTE: Non-PCP providers must have a PCP referral on file for Medicaid patients.

The undersigned physician certifies that the ordered tests are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.
Physician
Signature: _____ Date: _____

Last Name_____ First Name_____

Patient 10 Digit ACH MRN: M _____
Sex: ☐ Male ☐ Female Date of Birth: _____

Please list all diagnoses codes for each lab that has been ordered:
Diagnosis / ICD 10 Code (s)
1. _____
2. _____
3. _____

PLEASE ATTACH A COPY OF ID AND INSURANCE CARD
(if applicable)

Collection Date:
Collection Time:
Collectors Name:

X	LAB #	TEST NAME
	LAB429	Acylcarnitine
	LAB811	Amino Acid Plasma
	LAB355	Amino Acid Urine
	LAB518	Androstenedione
	LAB958	Biotinidase
	LAB815	Carnitine Free & Total
	LAB3653	Carnitine Urine
	LAB1748	CBC with diff
	LAB4770	CFTR Comp Reflex **
	LAB61	Cortisol
	LAB3495	Galactitol Urine
	LAB995	Galactose-1-Phosphate, RBC
	LAB4497	GALT Enzyme, RBC
	LAB2900	Hemoglobin Electrophoresis w/interp * (Consent not necessary)
	LAB93	Homocysteine Total
	LAB720	17-Hydroxyprogesterone
	LAB480	Newborn Screen
	LAB418	Organic Acid Urine
	LAB3587	Phenylalanine/Tyrosine
	LAB4488	Spinal Muscular Atrophy **
	LAB127	T4, Free
	LAB126	T4, Total
	LAB3765	TSH
Test(s) Not Listed Above:		

Specimen Mail Address: Clinical Laboratory/Arkansas Children's Hospital, 1 Children's Way, Slot 820, Little Rock, AR 72202. (501)-364-1300 PH, (501)-364-3578 FAX

*CBC w/diff required (auto populates upon ordering), and consent must accompany the requisition for the test.
**Consent form must accompany the requisition when test is ordered.

April, 2024