U I D L
U I Diagnostic Laboratories

RESET

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Client Services Fax: 319-384-7213
Billing Fax: 319-356-0729

UIDL Toxic Alcohols (Glycols and Alcohols) LABORATORY REQUISITION

FOR CLIENT USE ONLY: Requisition Date:_____
Completed By: _____ Accn# _____

FOR UIDL USE ONLY: UIDL Accn #_____
UIDL MRN#

PART A - PATIENT INFORMATION - *Required*		
Patient Last Name:		
Patient First Name:		
Street:		
City:	St:	Zip:
Phone:		
Date of Birth:	Gender: ☐Male ☐Female	

PART B - PROVIDER INFORMATION - *Required*		
Referring Institution:		
Street:		
City:	St:	Zip:
Phone:	Fax:	
Referring Physician:		
Contact person for results:		
Fax number for results :		
Phone number for STAT results:		

Date Collected: __/___/___
Time Collected: _____

Specimen Type:
☐ **Plasma PST**

Call laboratory at 319-356-3527 for additional acceptable specimen collection containers.

Contact the UIHC Clinical Pathology Resident On-Call for assistance in ordering the proper testing. Call 1-319-356-1616 & ask operator to page #3724 (M-F, 08:00-17:00) OR #3404 (all other times).

IMPORTANT:
Approval from UIHC Clinical Pathology Resident is MANDATORY for gas chromatography testing.

Required ICD-10 codes: 1. 2. 3. 4.

TEST(S) REQUESTED

Contact the UIHC Clinical Pathology Resident On-Call for assistance in ordering the proper testing. Call 1-319-356-1616 & ask operator to page #3724 (M-F, 08:00-17:00) OR #3404 (all other times).

☐ **INITIAL TESTING:** Toxic Alcohol/Volatiles Screen (TAVS; LAB8785)

SUBSEQUENT TESTING options:

☐ Ethylene Glycol Rapid Assay (EGLYC; LAB7453)

☐ Alcohols Panel (Methanol, Ethanol, Isopropanol, Acetone) by Gas Chromatography (ALCH; LAB551)

☐ Glycols (Ethylene and Propylene) By Gas Chromatography (GLYCOL; LAB615)

REQUIRED: ☐ ***I acknowledge that I have received approval from the UIHC Clinical Pathology Resident for gas chromatography testing if requested.***

Clinical history and suspected ingestion:

BILLING

☐ **Referring Institution**
Billing Contact Person: _____
Address: _____
City, State, Zip_____
Phone: _____ Fax: _____
E-mail: _____

☐ **Patient's Insurance**
PRIMARY Insurance
Insured by:_____
Policy/ID #: _____ Group #:_____
Name of Subscriber: _____DOB_____
Relationship to Patient_____

SECONDARY Insurance
Insured by:_____
Policy/ID #: _____Group #:_____
Name of Subscriber: _____DOB_____
Relationship to Patient_____

NOTE:
Claims can't be submitted to Medicaid programs outside of Iowa.

See website for a comprehensive guide to UIDL Billing - https://uidl.medicine.uiowa.edu/billing

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for the Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens.

PRINT

4/28/2025 CLG