2016

L/S RATIO OR LUNG PROFILE DETERMINATION ANALYSIS

2016

Medical Genetics – Wake Forest University School of Medicine – Winston Salem NC
www.wfubmc.edu/medicalgenetics Phone: 336-716-4321 Fax: 336-716-2554

Collection Date: _____ **Time**: _____ am/pm

WFU LAB #: _____

Name: _____/_____/_____/_____
(Please print) **Last** **First** **Middle** **Maiden**

Address: _____/_____/_____/_____**Daytime Phone:(____)_____**
Mailing Address **City** **State** **Zip**

Birth Date: _____ **SS#** : _____ **Patient's Mother's first name:_____**

Hospital Name : _____ **Hospital/Unit #:** _____

Gestation: **_____** ***weeks*** ***Type of Specimen:*** ☐ **Amniotic Fluid** ☐**Vaginal Pool** ☐ **Other:_____**

COLLECTION TECHNIQUE:

At least 8cc's of amniotic fluid are required for a fetal lung profile. Send Labeled Specimen in a Water Tight Container on Ice.

Physician/Provider Order Physician: Last, First / Phone/beeper	
1.	
X.	
X. Physician Signature Required	
2.	
3.	

Statement of Financial Responsibility

I authorize any holder of medical or other information about me to release to my healthcare provider, third party processor, the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this health care encounter or related claim. I permit a copy of this authorization to be used in place of the original, and request payment of authorized insurance benefits be made on my behalf to the WFU Physicians. I understand I am responsible for payment of these charges. I am also responsible for payment if my insurance carrier decides this is a non-covered service or requires prior authorization, which I did not obtain.

Patient Signature: _____ **Date:** _____

Billing Information

Bill: ☐ Forsyth Hospital/Novant ☐ Moses Cone Hospital ☐ Wesley Long Hospital
☐ Solstas ☐ Women's Hospt of Greensboro ☐ Other - hospital/client's name:_____

**********The hospital or client will be billed for L/S Ratio samples**********

SIGNS/SYMPTOMS/INDICATION (ICD-10 CODES) FOR L/S RATIO STUDY

Indicate all that apply. **Codes here do not represent entire listing of ICD-9 codes available**. Please consult current ICD-10 code book for complete listing..

☐ Primary pulmonary immaturity NOS (P07.00) ☐ Pre-Eclampsia (O14) ☐ Early onset of delivery (O60.14X0)
☐ Diabetes mellitus (O24.92 ☐ Hypertension (P29.2) ☐
☐ **Other Clinical / ICD-10 codes specify**:_____

Test Requested **Note:** When ordering tests for which **Medicare** reimbursement will be sought, it is recommended that the Provider consult any Local Medical Review Policies (**LMRP**) or National Coverage Decisions (**NCD**) that may be applicable to the test(s) being ordered. Based on guidance issued in either of these policies it may be necessary to obtain an Advanced Beneficiary Notice (**ABN**) from the Medicare Patient. For Medicaid and other carriers a signed **Statement of Financial Responsibility** from the patient may be necessary. (See Statement of Financial Responsibility at top of form.)

SEND TO:

MEDICAL GENETICS, Room G-002, Hanes Bldg.
Attn: David Stafford
WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER
WINSTON-SALEM, NC 27157
PHONE: (336) 716-2549 Fax (336) 716-2554

- ***For Same Day Results, Specimen Must be Received in the Laboratory by 1:30 PM.***
- ***If Received After 1:30 PM, Specimen are run the Next Morning. Results usually are reported by 5:00 PM.***

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Collection Date: _____ **Time**: _____ am/pm

WFU LAB #: _____

WFU Lab Use Only

DATE RECEIVED_____**cc's**_____ **Fluid Condition**_____

REPORTED TO_____ **DATE**_____ **TIME**_____

L/S RATIO_____**/1.0** ☐ **with PG** ☐ **No PG**

FOR L/S LABORATORY USE ONLY

Name: _____ Lab #:_____
last first middle maiden

Date Received:_____/_____/_____ **Time Received**: _____

Sample Type: [ ] Amniotic Fluid [ ] Vaginal Pool [ ] Other_____

Fluid appearance: [ ] clear [ ] cloudy [ ] bloody [ ] brown [ ] clotted

Amount of fluid: _____ mls

Number of Tubes / collection containers: [ ] 1 [ ] 2 [ ] 3 [ ] 4

Additional Specimen Evaluation:_____

_____

REPORT OF RESULTS / SPECIMEN SUMMARY

[ ] Final [ ] Preliminary Read Back [ ] Date_____Tech_____

To:_____

INTERPRETATION: [ ] normal_____

[ ] abnormal:_____

To:_____By:_____ Date_____