

<p style="text-align: center;">KY Division of Laboratory Services 100 Sower Blvd., North Loading Dock P.O. Box 2020 Frankfort, Kentucky 40602-2020 Phone: 502/564-4446 Fax: 502/564-7019 Paul Bachner, MD, FCAP, Director</p> <hr/> <p style="text-align: center;"><i>Please complete a separate form for each specimen.</i></p>	 <p style="font-size: small;">Kentucky Public Health Protect. Promote. Prevent.</p> <h2 style="margin: 0;">Clinical Chemistry</h2>
PATIENT INFORMATION:	
Name (Last, First, MI) _____	
Social Security # _____ Sex _____ Race _____ Age _____ DOB _____	
Home Address _____	
City _____ State _____ Zip Code _____ County _____	
Send Report To:	
Submitter _____	
Street Address (PO BOX) _____	
City _____ State _____ Zip Code _____	
Specimen Information:	
Specimen Collection: Date _____ Time _____ AM PM	
Is the patient Fasting: <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
----- <i>Please fill in for timed glucose specimens as applicable:</i>	
Fasting _____ 2 Hour _____ Collection time Collection time	
1 Hour _____ 3 Hour _____ Collection time Collection time	
Examination Requested: <i>Must indicate test to be performed. (See Reverse Side.)</i>	
<input type="checkbox"/> Total Cholesterol (only) <input type="checkbox"/> Fasting Plasma Glucose*	
<input type="checkbox"/> Lipid Profile <input type="checkbox"/> Random Plasma Glucose*	
<input type="checkbox"/> Prenatal 1 Hour Glucose*, Post 50 gm. Load	
<input type="checkbox"/> Postpartum Fasting Plasma Glucose*	
<input type="checkbox"/> Glucose Tolerance Test*, Prenatal / Postpartum (<i>circle one</i>)	
*Specimens must be mailed in an appropriate container with ice pack	
For Cholesterol and Lipid Profile please indicate the program and mark the risk factors:	
PROGRAM : <input type="checkbox"/> Family Planning <input type="checkbox"/> Chronic Disease	
RISK FACTORS:	
<input type="checkbox"/> Cigarette Smoker <input type="checkbox"/> Obesity (30% Overweight or Greater)	
<input type="checkbox"/> Hypertensive <input type="checkbox"/> Age 40 or Over	
<input type="checkbox"/> Family History of Premature CHD <input type="checkbox"/> Family History of High Cholesterol	
<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Sedentary Lifestyle	

Please Use "L" Label or Fill in Completely