PARKLAND HEALTH
Dallas, Texas

LABORATORY SERVICES

ORD 176

Point-of-Care Order & Result Form

Place Demographic Label Here
If label not available, please complete manually.

MRN: _____ Name (Last, First): _____

DOB: _____ Race: _____

HAR: _____ Sex: _____

CSN: _____ Location: _____

❑ STAT ❑ Fasting ❑ Non-Fasting | Date | Time

Test Reason* Write reason number next to each test requested. **INPATIENTS** (Chief complaint) 1._____ 2._____ **OUTPATIENTS** (Diagnosis code) 1._____ 2._____

Medical Necessity: Provider should only order tests that are reasonable and necessary for the diagnosis or treatment of a patient. Documentation of medical necessity is required for each test ordered. Tests for screening purposes may be ordered but may not be reimbursed. To order screening tests on Medicare patients, use Screening Lab Requisition (form 6197).

✓	TEST NAME	TESTER ID #	RESULT	REF. RANGE
	POC Glucose		mg/dL	**
	Hemoglobin A1c POC		%	4.9 – 6.2%
	Pregnancy Test Urine, POC			Negative
	Hemoglobin, measured, POC		g/dL	**
	HCT, spun		%	**
	Strep A Antigen			Negative
	Rapid HIV-1 / HIV-2 Antibody			Negative

✓	TEST NAME	TESTER ID #	RESULT	REF. RANGE
	Protime w/INR		seconds	10.2 – 13.0
	(Critical INR >5.0)			0.9 - 1.3
	Influenza A Antigen			Negative
	Influenza B Antigen			Negative
	SARS (Covid) Antigen			Negative
	Bacterial Vaginosis POC			Negative
	Trichomonas POC			Negative
	Syphilis Antibody			Negative

VAGINAL WET PREP

Epithelial Cells: ❑ Few ❑ Moderate ❑ Many Clue Cells? ❑ Yes ❑ No
RBCs: ❑ None ❑ Few ❑ Moderate ❑ Many
WBCs: ❑ None ❑ Few ❑ Moderate ❑ Many
FERN TEST: ❑ Present ❑ Absent

Yeast: ❑ Not Present ❑ Present w/ Budding ❑ Present w/Hyphae
Trichomonas: ❑ Not Present ❑ Present/Motile
Bacteria: ❑ Few ❑ Moderate ❑ Many
KOH (WHIFF) Test (for amine odor): ❑ Negative ❑ Positive

URINE DIP ONLY / **URINALYSIS** | Source: | Tester ID #

Color: | Clarity:

DIPSTICK	RESULT	REFERENCE RANGE
Glucose	❑ Negative ❑ 100 ❑ 250 ❑ 500 ❑ 1000 ❑ ≥1000 ❑ ≥2000	Negative (mg/dL)
Bilirubin	❑ Negative ❑ Small ❑ Mod ❑ Large	Negative
Ketones	❑ Negative ❑ Trace ❑ 5 ❑ 15 ❑ 40 ❑ 80 ❑ ≥80 ❑ 160	Negative (mg/dL)
Specific Gravity	❑ 1.000 ❑ ≤1.005 ❑ 1.005 ❑ 1.010 ❑ 1.015 ❑ 1.020 ❑ 1.025 ❑ 1.030 ❑ ≥1.030	1.002 - 1.030
Blood	❑ Negative Non Hemolyzed ❑ Trace ❑ Mod Hemolyzed: ❑ Trace ❑ Small ❑ Mod ❑ Large	Negative
pH	❑ 5.0 ❑ 5.5 ❑ 6.0 ❑ 6.5 ❑ 7.0 ❑ 7.5 ❑ 8.0 ❑ 8.5 ❑ ≥ 9.0	5.0 - 7.0 (pH units)
Protein	❑ Negative ❑ Trace ❑ 30 ❑ 100 ❑ 300 ❑ ≥300 ❑ ≥2000	Negative/Trace (mg/dL)
Urobilinogen	❑ 0.2 ❑ 1.0 ❑ 2.0 ❑ 4.0 ❑ 8.0 ❑ ≥8.0	0.2 - 1.0 (EU/dL)
Nitrite	❑ Negative ❑ Positive	Negative
Leukocytes	❑ Negative ❑ Trace ❑ Small ❑ Mod ❑ Large	Negative

CHEMISTRIES **

❑ Na+ _____mmol/L
❑ K+ _____mmol/L
❑ Cl- _____mmol/L
❑ Gluc _____mg/dL
❑ BUN _____mg/dL
❑ TCO_2 _____mmol/L
❑ Anion Gap _____mmol/L
❑ iCA _____mg/dL
❑ Creatinine _____mg/dL
❑ Lactate _____mmol/L

BLOOD GASES **

❑ ART / ❑ VEN / ❑ CAP
pH _____
pO_2 _____mmHg
pCO_2 _____mmHg
HCO3 _____mmol/L
BE _____mmol/L
sO2 _____%
HCT _____%
Hgb _____ g/dL

Tester ID #

Legend:
*=Required Field
** =See www.ParklandLab.com for ranges and critical values

TESTING LOCATION*: see www.parklandlab.com for more details

IMPORTANT to mark testing location

❑ ACH (Parkland) Unit_____
❑ MOC (Parkland) Loc _____
❑ RJA(Parkland) Loc _____
❑ ASC
❑ BFHC
❑ CVRO/CVRO ARC
❑ DHHC
❑ FMC
❑ GERI
❑ GHC/Garland ARC
❑ GMP III
❑ GPHC
❑ H@H
❑ HSHC
❑ IHC
❑ Jubilee Park
❑ LW WHC
❑ OWHC/PD @ OWHC
❑ Richland HC
❑ SDHC/SE ARC
❑ VHC
❑ Wynnewood ARC
❑ YFC-Vivian Field
❑ HOMES-Bridge
❑ HOMES-Stew Pot
❑ HOMES-Deflection Ctr
❑ HOMES-Van #_____
❑ Maple Mobile Unit
❑ Correctional Health-North Tower
❑ Correctional Health-West Tower
❑ Correctional Health-Kays Tower
❑ Correctional Health-Henry Wade
❑ Correctional Health-Letot
❑ Correctional Health-Medlock
❑ Correctional Health-Youth Village
❑ Correctional Health-JJAEP
❑ Other:
❑ Community Health Event: _____

Critical Value
Result:_____
Called to:_____
Time: _____
Readback: Y or N

Ordering Provider Signature	Ordering Provider Printed Name	ID #	Pager/Phone #	Order Date	Order Time
Authorizing Provider Signature	Authorizing Provider Printed Name	ID #	Pager/Phone #	Order Date	Order Time
Tester Signature	Tester Printed Name	Initials	ID #	Date	Time
Tester Signature	Tester Printed Name	Initials	ID #	Date	Time
Practitioner Result Review Signature	Practitioner Result Review Printed Name	Initials	ID #	Date	Time