Open Arm
Mental Health

NORTHWEST OPEN ARM MENTAL HEALTH

LABORATORY REQUEST FORM

Psychiatric assessment, baseline testing & medication monitoring

Patient & Ordering Information

Patient name: _____ Date of birth: _____ Age: _____

Sex (for reference ranges / pregnancy testing): _____ Phone: _____

Address: _____

Insurance carrier: _____ Member ID: _____

Ordering clinician: Patrick Masiasia, APRN, CNP, PMHNP-BC NPI: _____

Clinic address / phone / fax for results: _____

Order date: _____

Priority: ☐ Routine ☐ Urgent

Fasting: ☐ Yes ☐ No ☐ N/A

Preferred laboratory: _____ Lab fax / phone: _____

Laboratory Tests — Select as Clinically Indicated

General / baseline health

☐ CBC with differential ☐ Comprehensive metabolic panel (CMP) ☐ Basic metabolic panel (BMP)
☐ Lipid panel ☐ Hemoglobin A1c ☐ Fasting glucose
☐ TSH ☐ Free T4 ☐ Urinalysis (UA)
☐ Urine culture (if indicated) ☐ Urine pregnancy test ☐ Serum pregnancy (hCG)
☐ Vitamin B12 ☐ Folate ☐ 25-OH Vitamin D
☐ Iron / ferritin / TIBC ☐ Magnesium ☐ Phosphorus
☐ ESR / CRP (if indicated)

Psychiatric medication monitoring / therapeutic drug levels

☐ Lithium level (12-hour trough; document last dose) ☐ Valproic acid / valproate level ☐ Carbamazepine level
☐ Clozapine monitoring (CBC / ANC) ☐ Liver function tests (LFTs) ☐ Renal function (BUN / creatinine / eGFR)
☐ Prolactin ☐ Ammonia (if indicated)
☐ Other medication level: _____

Toxicology / substance screening

☐ Urine drug screen (UDS) — standard panel ☐ Expanded / confirmatory toxicology ☐ Alcohol / ethanol
☐ Ethyl glucuronide (EtG), if indicated
☐ Other: _____

Infectious disease / other tests (when clinically indicated)

☐ HIV Ag/Ab ☐ Hepatitis B panel ☐ Hepatitis C Ab

☐ Syphilis screen (RPR / treponemal) ☐ GC / chlamydia NAAT ☐ TB screening (IGRA / other)

☐ Pharmacogenomic testing

☐ Other: _____

Clinical Information & Special Instructions

Diagnosis / ICD-10 code(s): _____

Clinical indication / reason for testing: _____

Current psychiatric medications / dose: _____

Last dose / collection timing (if relevant): _____

Special instructions: ☐ Fasting ☐ Timed trough ☐ Call critical results ☐ Other: _____

Patient informed of tests ordered and reason for testing (including any toxicology, HIV, hepatitis, or STI testing): ☐ Yes Staff initials: _____

Ordering clinician signature: _____ Date: _____

Printed name: _____ Callback number: _____

Clinical use notice: This requisition is a selection aid, not a standing panel. Order only tests supported by the patient's presentation, medication regimen, history, and applicable monitoring guidance. Confirm specimen requirements, fasting status, timing, and coverage with the performing laboratory.