

Patient Name: \_\_\_\_\_  
(please print)

DOB: \_\_\_\_\_ Sex: M F

Client Supplied Patient ID: \_\_\_\_\_

Bill to WI Medical Assistance  
Provide request information if Wisconsin Medical Assistance

Home Address \_\_\_\_\_  
City/State/ Zip \_\_\_\_\_  
WI Medical Assistance # \_\_\_\_\_  
Provider Signature \_\_\_\_\_  
Signature Date/Time \_\_\_\_\_

Client Name: \_\_\_\_\_ Client Code: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Collect Date: \_\_\_\_\_ Collect Time: \_\_\_\_\_

Billing/Authorizing Provider (Attending MD, NP, PA)  
\_\_\_\_\_

Fax #: \_\_\_\_\_

Contact #: \_\_\_\_\_

Diagnosis or ICD-10 Code \_\_\_\_\_

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order those tests that are medically necessary for the diagnosis or treatment of a patient rather than for screening purposes.

For specific instructions or handling information for each test, refer to [www.uwhealth.org/lab](http://www.uwhealth.org/lab) and click on the "Lab Test Directory" or call (608) 263-7060 or 1-800-323-8942 ext. 3-7060

**OPTION A: For Suspected Methanol, Isopropanol, or Ethylene Glycol Ingestion**

- Ethylene Glycol and Volatiles testing is performed stat when received between the hours of:  
0700 – 1600 Weekdays  
Weekends/Holidays- when Toxicology Lab is staffed.
- These tests will be assayed stat after-hours if:
  - The patient is younger than 18 years old *OR*
  - The patient is 18 years or older and has an Osmo Gap >15 by this calculation:  
$$\text{Osmo Gap} = \text{Osmolality} - [(\text{Sodium} \times 2) + (\text{Glucose}/18) + (\text{BUN}/2.8) + (\text{Ethanol}(\text{mg/dL})/4.6)]$$
*If neither of these two criteria are met for samples received after-hours, testing will be completed the next dayshift.*

**Select one screen:**

|   |
|---|
| <b>Ethylene Glycol and Volatiles Screen, Adult- VGAP</b><br><i>Includes methanol, isopropanol, acetone, ethanol, ethylene glycol, sodium, BUN, glucose and osmolality.</i> <ul style="list-style-type: none"><li>GREEN top, no gel. Do not open or centrifuge. <b>Send minimum of 1 mL heparinized whole blood.</b></li><li>RED top, no gel. Centrifuge and aliquot serum to plastic vial. <b>Send minimum of 2 mL serum.</b></li><li>GREEN cap with yellow ring (PST). Centrifuge. <b>Send minimum of 1 mL plasma.</b></li></ul> |
| <b>Ethylene Glycol and Volatiles Screen, Adult- VGAPNC</b> <ul style="list-style-type: none"><li><b>Attach</b> patient report with Sodium, BUN, Glucose, Alcohol &amp; <b>Measured</b> Osmolality results.</li><li>GREEN top, no gel. Do not open or centrifuge. <b>Send minimum of 1 mL heparinized whole blood.</b></li><li>RED top, no gel. Centrifuge and aliquot serum to plastic vial. <b>Send minimum of 2 mL serum.</b></li></ul>   |
| <b>Ethylene Glycol and Volatiles Screen, Pediatric- VGAPP</b> <ul style="list-style-type: none"><li>GREEN top, no gel. Do not open or centrifuge. <b>Send minimum of 0.5 mL heparinized whole blood.</b></li><li>RED top, no gel. Centrifuge and aliquot serum to plastic vial. <b>Send minimum of 0.5 mL serum.</b></li></ul>  |

**OPTION B: For Follow-up of Confirmed Methanol, Isopropanol, and/or Ethylene Glycol Ingestion**

**Check confirmed test(s).** Note: A Testing Plan should be coordinated with a UWHC Clinician.

|                              |  |                              |
|------------------------------|--|------------------------------|
| Methanol- <b>MEOH</b>        | GREEN top, no gel. Do not open or centrifuge.                | 1 mL heparinized whole blood |
| Isopropanol- <b>ISOH</b>     | GREEN top, no gel. Do not open or centrifuge                 | 1 mL heparinized whole blood |
| Ethylene Glycol- <b>ETGL</b> | RED top, no gel. Centrifuge & aliquot serum to plastic vial. | 1 mL serum                   |

**For Option A or B--ALL Results are Called. Fill in Contact and Ordering Clinician Contact Information**

Contact Name: \_\_\_\_\_ Phone or Pager #: \_\_\_\_\_

*If the patient is positive for ingestion, a UWHC clinician will contact the ordering clinician to develop a testing plan for follow-up. Indicate ordering clinician contact information if different.*

Ordering Clinician Name: \_\_\_\_\_ Phone or Pager #: \_\_\_\_\_