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NAME: _____ **FASTING:** **YES** **NO**
DOB: ____ / ____ / _____

√	LAB TESTS	<u>DIAGNOSIS FOR THE TODAY'S TESTS</u>
	CBC W/DIFF	
	CMP	
	LIPID PROFILE	<input type="checkbox"/> Constipation (K59.04)
	HGB A1C	<input type="checkbox"/> Diarrhea (K59.1)
	TSH / Free T3 / Free T4	<input type="checkbox"/> Mal-Abs (R19.7, K90)
	HEPATITIS A IgM	<input type="checkbox"/> Abdo Pain (R10.84)
	HEPATITIS A IgG	<input type="checkbox"/> Anemia (D50.0)
	HEPATITIS B COMPLETE PROFILE	<input type="checkbox"/> Lipid (E78.5)
	HEPATITIS B DNA QUANTITATIVE	<input type="checkbox"/> NIDDM (Z13.1)
	HEPATITIS C Antibody With Reflex for HCV Antibody Verification	<input type="checkbox"/> Dysuria (R30.0)
	HCV RNA PCR QUANTITATIVE (HCV viral load)	<input type="checkbox"/> Wt loss (R63.4)
	HEPATITIS C GENOTYPE	<input type="checkbox"/> CD (K50.011)
	LKM AB	<input type="checkbox"/> UC (K51.011)
	ANA	<input type="checkbox"/> Colitis (K52)
	ANTISMOOTH MUSCLE ANTIBODY	<input type="checkbox"/> IBS (K58 /K58.1)
	ANTIMITOCHONDIAL ANTIBODY	<input type="checkbox"/> Chronic liver ds
	IMMUNOGLOBULINS, Quantitative, IgA,IgG,IgM,IgE Serum	(B18.1, B18.2, R94.5, K73, K74.69)
	SERUM CERULOPLASMIN	<input type="checkbox"/> Biliary / pancreatic ds
	ALPHA 1 ANTITRYPSIN PHENOTYPE	(C25.3)
	FIBROSURE <input type="checkbox"/> NASH <input type="checkbox"/> HCV	<input type="checkbox"/> Prostate disease (N40)
	PT / INR / PTT	
	HIV-1/HIV-2 ANTIBODY SCREEN	
	HEMOGLOBIN ELECTROPHORESIS	
	CELIAC DISEASE PANNEL	
	ADULT FOOD ALLERGY PANNEL	
	ESR & CRP	
	SERUM IRON / FERRITIN / TIBC	
	HFE GENE ANALYSIS (H63 D AND C211Y) FOR HEMOCHROMATOSIS	
	VITAMIN B12 & FOLATE LEVEL	
	ANTI PARIETAL CELL AND ANTI INTRINSIC FACTOR ANTIBODIES	
	VITAMIN D – 25 HYDROXY	
	TB GOLD QUANTIFERON	
	IBD PANEL	
	6MP Metabolites – 6 TGN and 6 MMP levels	
	TPMT (Thiopurine Methyltransferase Quantitative Level)	
	<input type="checkbox"/> Anti Humira antibodies <input type="checkbox"/> Humira Level	
	<input type="checkbox"/> Anti Infliximab (Remicade) antibodies <input type="checkbox"/> Infliximab level	
	<input type="checkbox"/> CA 19-9 <input type="checkbox"/> PSA <input type="checkbox"/> CEA	
	ALPHA FETOPROTEIN TUMOR MARKER SERUM	
	URINE DRUG SCREEN	
	URINE ANALYSIS	

SIGNATURE



DATE ____ / ____ / ____

****IT IS THE PATIENT'S RESPONSIBILITY TO USE A LAB COVERED BY THEIR INSURANCE**.**