

Date of Request _____ Visit Number: _____

Chart #: _____ Location: _____

Name Last: _____ First: _____

Date of Birth _____



**BASSETT HEALTHCARE NETWORK
TRANSFUSION / TISSUE/DOWNTIME**

Ordering Provider: _____ * 4 8 7 8 *

Attending Provider: _____

LAB TEST REQUEST FORM #3

#4878 (flabl.doc)

1/06,3/06,4/7/06,7/06,11/12/07,4/07,8/1/07,1/14/08,10/16/08,4/16/09,10/5/09,11/16/09,1/4/10
7/19/2010,1/3/11,4/4/11,1/16/12,4/9/12,7/1/13,1/6/14,7/7/14,10/6/14,
5/14/15,8/4/15,1/17,9/7/23

Please circle requests below.
Check box for STAT. Unless indicated, tests are considered "Routine."

SPECIMEN	TIME: _____	DATE: _____
COLLECTED BY: _____		
WRISTBANDED BY: _____		

Diagnosis Code: _____
or
Descriptive Diagnosis: _____

PROVIDERS: Compliance is mandatory and regulated. For the laboratory to bill properly and receive payment, you must provide the specific Diagnosis Codes for each outpatient test ordered. Additionally, only tests that are medically necessary for the indicated diagnosis or treatment should be ordered, with supporting documentation in the medical record. Under current Medicare regulations, when certain laboratory tests (indicated by an *) are ordered, and the diagnosis is not listed in the Local Coverage Determination or National Coverage Determinations for that test, payment may be denied. In these cases Medicare requires an Advance Beneficiary Notice (waiver of liability) be signed to allow the hospital to bill the patient. The ABN box on the requisition **MUST** be checked when an ABN is obtained.

Patient has signed ABN Waiver (ABN) Patient refused to sign ABN Waiver (ABNR) ABN not required

BLOOD BANK TESTS

Code	Test Name	STAT
LAB286	Separate and Hold	<input type="checkbox"/>
LAB21083	Cord Blood Hold ⁵	<input type="checkbox"/>
LAB276	Type and Screen ¹	<input type="checkbox"/>
LAB21084	Cardiac TSC ²	<input type="checkbox"/>
LAB274	Direct Antiglobulin Test ³	<input type="checkbox"/>
LAB21070	Obstetrical Antibody Titer	<input type="checkbox"/>
LAB21071	Infant Group and Rh	<input type="checkbox"/>
LAB21072	Antigen Typing _____	<input type="checkbox"/>
LAB895	ABO/Rh Type Only	<input type="checkbox"/>

TRANSFUSION REACTION WORKUP

LAB893	Transfusion Reaction Workup	<input type="checkbox"/>
LAB21012	Routine Urinalysis ⁶	<input type="checkbox"/>

HLA TYPING FOR PLATELET REQUESTS ONLY

LAB21073	HLA A,B Antigen Typing ⁴	<input type="checkbox"/>
LAB21074	HLA Cytotoxic Antibody Screen ⁴	<input type="checkbox"/>

RHOGAM ORDERS

Code	Test Name	STAT
LAB21075	Antepartum Rhogam (includes TSC)	<input type="checkbox"/>
	<input type="checkbox"/> Micro Dose (12 weeks gestation or less)	
	<input type="checkbox"/> Full Dose	
Rhogam needed on Date: _____ Time: _____ Location: _____		
LAB21076	PostPartum Rhogam	<input type="checkbox"/>
	Infant group and Rh results:	
	<input type="checkbox"/> A Positive <input type="checkbox"/> O Positive	
	<input type="checkbox"/> B Positive <input type="checkbox"/> AB Positive	

A Fetal Screen is included in a postpartum request for Rhogam. A Fetal Hemoglobin Stain will be performed for any Fetal Screen resulted as positive, invalid or when the baby is Weak D positive for the Rh(D) antigen, to determine the appropriate dose of Rhogam.

CROSSMATCH/ORDER OF BLOOD COMPONENTS

INSTRUCTIONS: Indicate the product that has been ordered by circling the appropriate code and indicating the # of units. RCP orders include a TSC (Type and Screen) and XM (crossmatch). CRCP includes CTS (Cardiac Type and Screen which includes a cold agglutinin screen) and XM (crossmatch). Indicate date, time and location of the planned transfusion for all products ordered. Circle an indication for use and any special requirements necessary for transfusion.

~ STAT ~ URG Planned Transfusion/Surgery Date: _____ Time: _____ Location: _____

Code	Component	# of Units	Code	Component	# of Units	Code	Component
LAB21077	Red Cell Products		LAB21079	Platelet Pheresis Products		LAB21080	Factor Products
Special Requirements: 1. Autologous 2. Directed 3. CMV Negative 4. Irradiated 5. Split/Aliquot 6. Washed Indication for use: 1. Active Bleed/Trauma 2. Hgb < 8 or Hct < 25 3. H/H > 8/25 with clinical risk factors 4. H/H > 8/25 ordered by an attending 5. Pre-op scheduled within 48 hours 6. Cardiac Surgery (use CRCP code) 7. Stay Ahead/ Number of Units _____			Special Requirements: 1. CMV Negative 2. Irradiated 3. HLA Matched 4. Crossmatched 5. None Indication for use: 1. Platelet Count <50,000. 2. Decrease platelet count, invasive procedure 3. Hematology/Oncology MD consulted. 4. Massive Transfusion 5. No platelet count available.			Type of Product 1. Factor VIIa (Novoseven) 2. Factor VIII (Recombinant) 3. Benefix-Factor IX (Recombinant) 4. Other: _____ Other information required: Date/Location of diagnosed deficiency: _____ Patient weight: _____ (kgs) Desired Factor Level (% Activity): _____ Dosage: _____ International Units Frequency of Dose: _____	

Code	Component	# of Units	Code	Component	# of Units	TISSUE PRODUCT	
LAB21081	Plasma Products		LAB21082	Cryoprecipitate		Product: _____ Size/Volume: _____ Quantity: _____	
Indication for use: 1. PT/PTT above normal range. 2. Reversal of anti-coagulant therapy. 3. Hematology MD consulted. 4. Invasive procedure. 5. No PT/PTT results available.			Indication for use: 1. Hemophilia A/Factor VIII 2. Hypofibrinogenemia 3. VonWillebrand's Disease			Provider's Signature: _____ Signed Date and Time: _____ Received by: _____	

REQUISITIONS LAB

REFLEXIVE TESTING

1. When atypical antibodies are detected, antibody identification studies may be performed.
2. When atypical antibodies are detected, antibody identification studies will be performed. If a nonspecific Cold Agglutinin has been identified, a Cold Agglutinin Titer and Thermal Amplitude Studies will be performed.
3. When DAT is positive due to IgG, eluate study may be performed (only if patient has been pregnant or transfused in past three months).
4. Testing performed by SUNY Upstate Medical University for HLA matched Platelet Requests only.
5. Infant group, RH and DAT will be performed on cord blood specimens collected on RH negative and Type O mothers.
6. A urine sediment examination is performed and billed when RTUA (LAB21012) is ordered and the sample is cloudy or an abnormality is detected.
7. For the Obstetrical Type and Screen received at time of delivery – When atypical antibodies are detected, antibody identification studies will be performed and 4 red cell products will be crossmatched at a minimum with products negative for the corresponding antibody.
8. Testing performed by Albany Medical Center for Fetal Hemoglobin Stain (LAB762) only.