MR #   DOB

NAME

DATE

BASSETT HEALTHCARE NETWORK
Cooperstown, NY 13326-1394

POINT OF CARE HEMOGLOBIN

H-8503 9/08;11/12;10/14;4/15 (d:\forms\hosp\.ofm)

BASSETT HEALTHCARE NETWORK

Location/Health Center ________________________________

Address: ________________________________

____

Test Date: ____________________ Test Time: ____________________ Tech Initials: ______________

Hemoglobin Result: ______________________ g/dL

Reference Ranges:

Newborn – 1 month	=	13.0–19.0 g/dL
1 – 5 months	=	11.0–17.0 g/dL
5 months – 2 years	=	11.0–14.0 g/dL
2 – 6 years	=	11.0–13.0 g/dL
6 – 12 years	=	11.0–15.0 g/dL
Female: > 12 years	=	11.5–15.5 g/dL
Male: > 12 years	=	11.5–18.0 g/dL

Reportable Range = 6.0-20.5 g/dL

☐ **Venous conformation for results < 6.0 g/dl**

Confirmatory Sample must be drawn for Hemoglobin < 6.0 g/dL.

(Please include a copy of this form with the sample. Please document actual hemoglobin values on the copy.)

Critical Value Documentation:

Critical Value = < 7.0 g/dL

Reported to: ____
(Ordering provider)

Date: ____________________ Time: ____________________

Reported by: ____
(Tech Name and Title)

Provider Signature/Order: ________________________________ Provider #: _______ Date: ____________ Time: _________

Provider Signature/Review: ________________________________ Provider #: _______ Date: ____________ Time: _________

POINT OF CARE Hemoglobin

White – Chart; **Yellow** – Coder