Shipping to Non-Mayo & ARUP Reference Laboratories:

Please use this guide to properly prepare specimens and paperwork for non-Mayo reference lab testing.

Your assistance in completing preparations will help ensure that there are minimal delays in getting the specimens out and getting results back in a timely manner.

For any questions not answered by these guidelines please call MIBH Lab Customer Service at 607-547-3866 or CLP at 607-547-3975.

MIB Lab be sure to log **all** specimen being sent out on the appropriate log.

On the copies of the requisitions, any field that is highlighted needs to be filled in.

Or, you may call a reference lab directly for test/shipping information using the following contact numbers:

Reference Lab	Phone #	Account Number
Albany Medical Center	518-262-4549	NA
ARUP	800-522-2787	295492
Athena	800-394-4493	38728
LabCorp	800-631-5250	31513500
Mayo Medical Lab	800-533-1710	MIB-7034108
Monogram	800-777-0177	00431
Quest	800-336-3718	11204
NYSDOH	518-474-4177	NA
URMC	585-758-0510 OPT #3	50790
Viracor	800-305-5198	3855

****Please note: If a patient's blood has to go outside the Bassett Network for testing due to the patient's type of insurance, it is the responsibility of the lab or clinic collecting the specimens to arrange for transportation and to send all necessary paperwork and insurance information. These specimens should never be sent to MIB to be forwarded, and they should never be billed to any Bassett reference lab account.**

Prepared by Houghton-Depietro, Brittany 02/21/2022 Updated 6/13/24 by Michelle Stepp

Transplant bloods (sent via UPS)

- Always open each tube to ensure it has been collected and labeled.
- Patient identifiers are different for clots; many only require last 4 digits of SSN and patient initials or partial name. This is ok.
- Order in LIS as TRANBLD.
- Send a copy of the requisition. Make copy of requisition to keep on file.
- Store and ship at room temperature.
- The complete shipping address should be available on the requisition or on the container. If no address is given, call the location where the specimen was collected. Ensure the address put on the UPS label matches the address given, especially room and department specifics.
- **Not shipped on Fridays**, but should be packaged and held in processing.
- Create an entry in the non-Mayo send out log
- Save a copy of the UPS label in the UPS file.
- **Create an entry in the non-Mayo send out log**.
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.

Stats to AMC (sent via stat LabLogistics courier)

- Process the specimens as necessary for the test(s) being performed.
- Fill out the appropriate requisition, ensuring the following information appears (all are REQUIRED): **Make copy of completed requisition to keep on file.**
    - 2 unique patient identifiers
    - Collection date and time of the specimen
    - Ordering provider information
    - Appropriate tests are check-marked or handwritten on
    - Tests are marked STAT as appropriate.
    - Include the ordering provider's fax information as well as fax info for CLP. Clearly indicate they should fax results STAT to both numbers.
- Order in LIS with correct test code. (If testing is being sent due to instrument at MIB being down the original testing needs to be TNP with comment of "Testing being sent to *** for testing." and reordered with a miscellaneous test code.)
- Place the specimen in a clear specimen bag with the paperwork in the pocket.
- Call LabLogistics or use the Rapid Ship interface to request a stat pickup.
- Fill out the "Special Trip" courier form including our contact information and the address of the lab it is going to. Indicate the temperature requirements of the specimen on the form. Indicate that it is STAT.
- Staple the form to the specimen bag and store in the courier area at the appropriate temperature.
- **Create an entry in the non-Mayo send out log**.
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.
- **When results are received in the lab:**
    - When the results are received into the lab deliver STAT to Customer Service to be scanned into LIS. If results are unable to be scanned into LIS manually fax results to ordering doctor.

Date of Request _____

Chart #: _____ Location _____

Patient Name _____

Date of Birth _____

Ordering Provider _____

BASSETT HEALTHCARE NETWORK
1 Atwell Rd
Cooperstown, NY 13326
Phone: (607)547-3975
Fax: (607)547-6717

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

Albany Medical Center Testing

- ☐ HAT: Heparin Antibody Test **STAT**
- ☐ Cyclosporin **STAT**
- ☐ Tacrolimus **STAT**
- ☐ Other_____

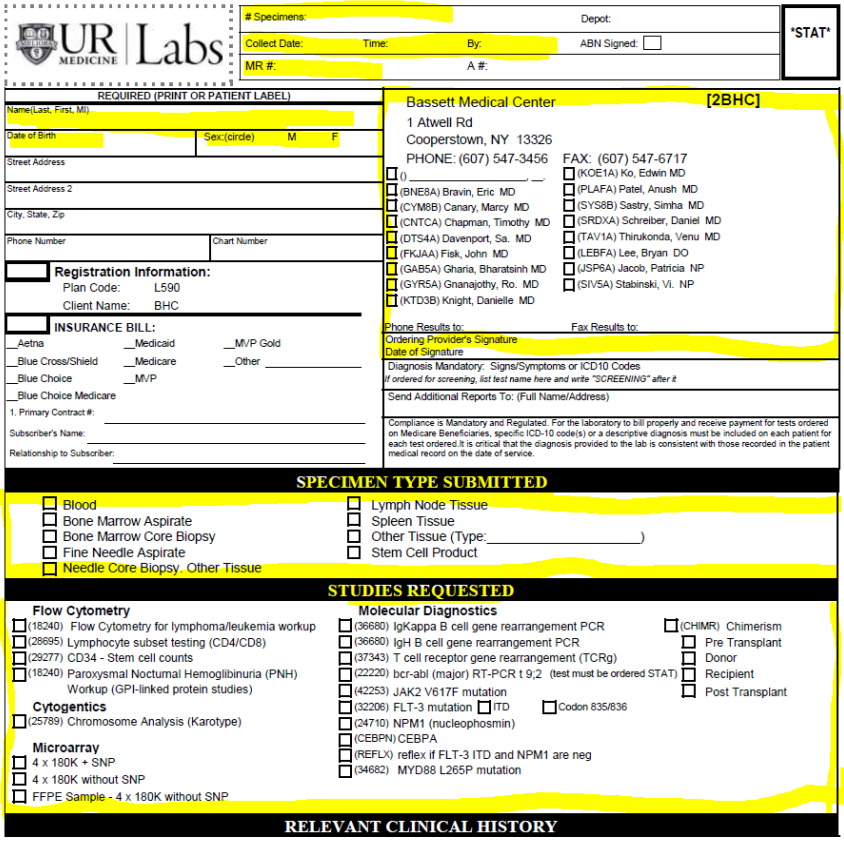
PLEASE FAX STAT RESULTS TO BASSETT MEDICAL CENTER LABORATORY AT 607-547-5438

AND TO THE ORDERING PROVIDER at:_____

Received By:_____

URMC (sent via daily courier pickup @ 1900*)

- All specimens for URMC must have the URMC requisition filled out to send with the specimen. Ensure the following information appears on the req (all are REQUIRED):
  - Patient name, male/female, DOB, MRN
  - Referring physician name, physician signature (if ordered in LIS transcribe the physicians name and indicate that Electronic signature on file)
  - Hospital status, ID# (accn #), body site (peripheral, bone marrow or core biopsy etc.), check appropriate boxes/mark number of each specimen type sent
  - Under Clinical History: Provider must fill out the diagnosis info, if electronically ordered reprint the requisition from Epic to send with the specimens.
  - Appropriate tests have been check-marked
- Submit billing for this visit with every patient
- Make sure that all test are ordered in the LIS.
- **Print the most recent CBC results to send with the specimens.**
- **Make copy of completed requisition to keep on file.**
- Place all specimens into a small specimen bag and then into a large clear courier bag.
- **Fill our URMC tracking log and attach to large courier bag**. This does not need to be logged on the non-Mayo send out log
- Place the bag in the designated space for URMC pickup.
- When the courier comes in the evening, the driver will verify the log and initial the log. A CLP person will verify and initials on the log. The yellow copy of the log will be kept in CLP in the binder designated URMC Logs.
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.



UR MEDICINE | Labs

Specimens: Depot: *STAT*

Collect Date: Time: By: ABN Signed: ☐

MR #: A #:

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI):

Date of Birth Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number Chart Number

☐ **Registration Information:**
Plan Code: L590
Client Name: BHC

☐ **INSURANCE BILL:**
__Aetna __Medicaid __MVP Gold
__Blue Cross/Shield __Medicare __Other _____
__Blue Choice __MVP
__Blue Choice Medicare
1. Primary Contract #:
Subscriber's Name:
Relationship to Subscriber:

Bassett Medical Center [2BHC]
1 Atwell Rd
Cooperstown, NY 13326
PHONE: (607) 547-3456 FAX: (607) 547-6717

☐ ( ) ____-____, __.
☐ (BNE8A) Bravin, Eric MD
☐ (CYM8B) Canary, Marcy MD
☐ (CNTCA) Chapman, Timothy MD
☐ (DTS4A) Davenport, Sa. MD
☐ (FKJAA) Fisk, John MD
☐ (GAB5A) Gharia, Bharatsinh MD
☐ (GYR5A) Gnanajothy, Ro. MD
☐ (KTD3B) Knight, Danielle MD
☐ (KOE1A) Ko, Edwin MD
☐ (PLAFA) Patel, Anush MD
☐ (SYS8B) Sastry, Simha MD
☐ (SRDXA) Schreiber, Daniel MD
☐ (TAV1A) Thirukonda, Venu MD
☐ (LEBFA) Lee, Bryan DO
☐ (JSP6A) Jacob, Patricia NP
☐ (SIVSA) Stabinski, Vi. NP

Phone Results to: Fax Results to:
Ordering Provider's Signature
Date of Signature
Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes
If ordered for screening, list test name here and write "SCREENING" after it
Send Additional Reports To: (Full Name/Address)
Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

SPECIMEN TYPE SUBMITTED

☐ Blood
☐ Bone Marrow Aspirate
☐ Bone Marrow Core Biopsy
☐ Fine Needle Aspirate
☐ Needle Core Biopsy- Other Tissue
☐ Lymph Node Tissue
☐ Spleen Tissue
☐ Other Tissue (Type:_____)
☐ Stem Cell Product

STUDIES REQUESTED

Flow Cytometry
☐ (18240) Flow Cytometry for lymphoma/leukemia workup
☐ (28695) Lymphocyte subset testing (CD4/CD8)
☐ (29277) CD34 - Stem cell counts
☐ (18240) Paroxysmal Nocturnal Hemoglibinuria (PNH) Workup (GPI-linked protein studies)

Cytogentics
☐ (25789) Chromosome Analysis (Karotype)

Microarray
☐ 4 x 180K + SNP
☐ 4 x 180K without SNP
☐ FFPE Sample - 4 x 180K without SNP

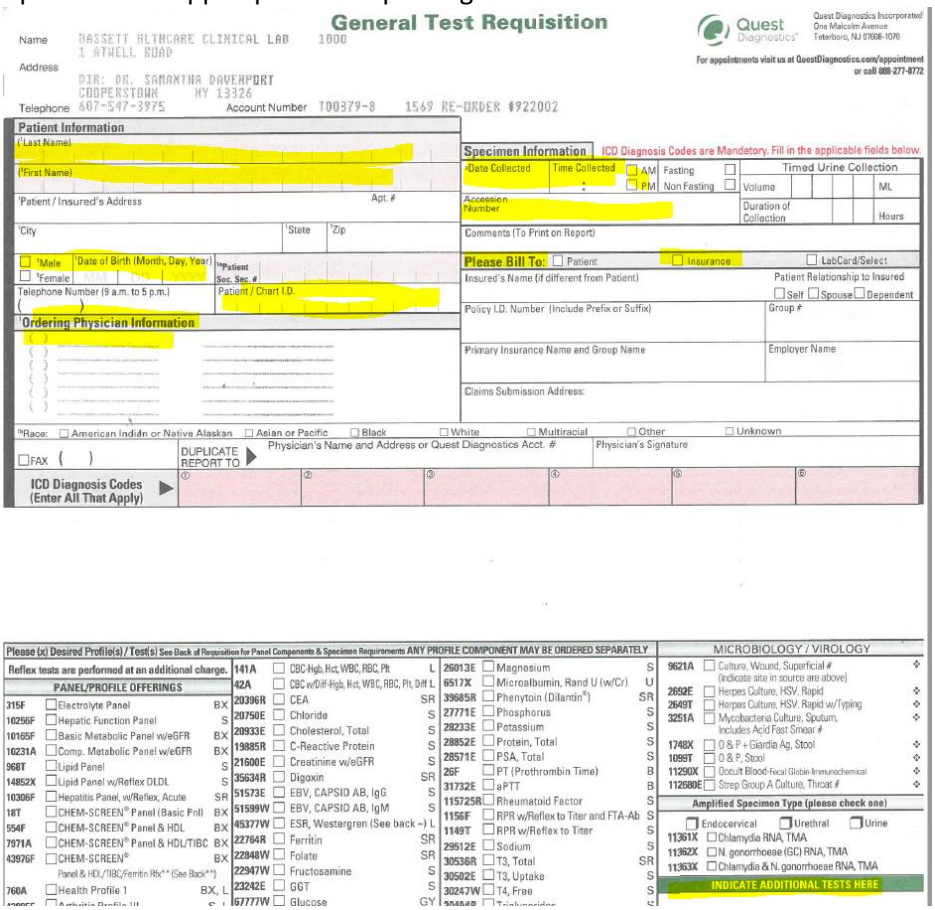
Molecular Diagnostics
☐ (36680) IgKappa B cell gene rearrangement PCR
☐ (36680) IgH B cell gene rearrangement PCR
☐ (37343) T cell receptor gene rearrangement (TCRg)
☐ (22220) bcr-abl (major) RT-PCR t 9;2 (test must be ordered STAT)
☐ (42253) JAK2 V617F mutation
☐ (32206) FLT-3 mutation ☐ ITD ☐ Codon 835/836
☐ (24710) NPM1 (nucleophosmin)
☐ (CEBPN) CEBPA
☐ (REFLX) reflex if FLT-3 ITD and NPM1 are neg
☐ (34682) MYD88 L265P mutation

☐ (CHIMR) Chimerism
☐ Pre Transplant
☐ Donor
☐ Recipient
☐ Post Transplant

RELEVANT CLINICAL HISTORY

Quest (sent via Quest courier)

- Process the specimens as necessary for the test(s) being performed.
- Be sure that all testing is ordered properly in the LIS.
- **Is specimen being sent to quest due to patients insurance?**
    - No- Enter orders into Quest Quanum
    - Yes: Fill out the proper Quest requisition. Ensure all of the following information appears on the requisition (all are REQUIRED):
        - Fill out patient info: Patient name, sex, DOB, age, patient ID (MRN), specimen ID (accn #), draw date, draw time
        - Physician name
        - Specimen type (serum, plasma, etc), temp, # tubes, total tests
        - Appropriate test(s) are check-marked or handwritten on. **Include Quest test ID number.**
        - Mark Bill To Insurance
        - Print patient insurance information and send with sample.
- **Keep copy of completed requisition to keep on file.**
- Place the specimen into a specimen bag and place copy of the requisition in bag .
- Store in the appropriate designated quest bin in the freezer, fridge or on the counter.
- **Create an entry in the Quest transport log.**
- Contact Quest to schedule a pick up at 866-697-8378 Client ID of 6075473456
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.



General Test Requisition

Quest Diagnostics

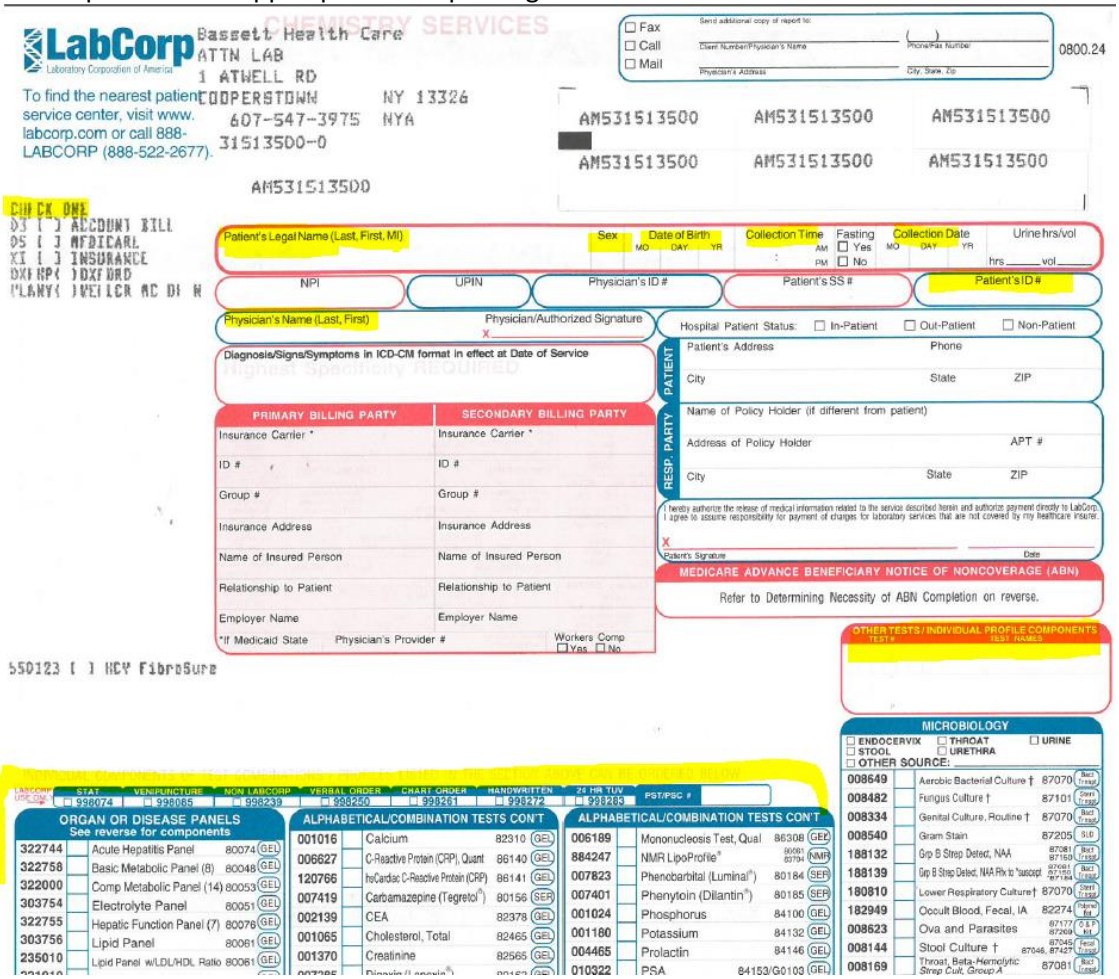
Name MASSETT HLTHCARE CLINICAL LAB 1000
Address 1 ATHELL ROAD
DIR: DR. SAMANTHA DAVENPORT
COOPERSTOWN NY 13326
Telephone 607-547-3975 Account Number T00379-8 1569 RE-ORDER #922002

Patient Information
Specimen Information
Please Bill To:
Ordering Physician Information
ICD Diagnosis Codes (Enter All That Apply)

MICROBIOLOGY / VIROLOGY
Amplified Specimen Type (please check one)
INDICATE ADDITIONAL TESTS HERE

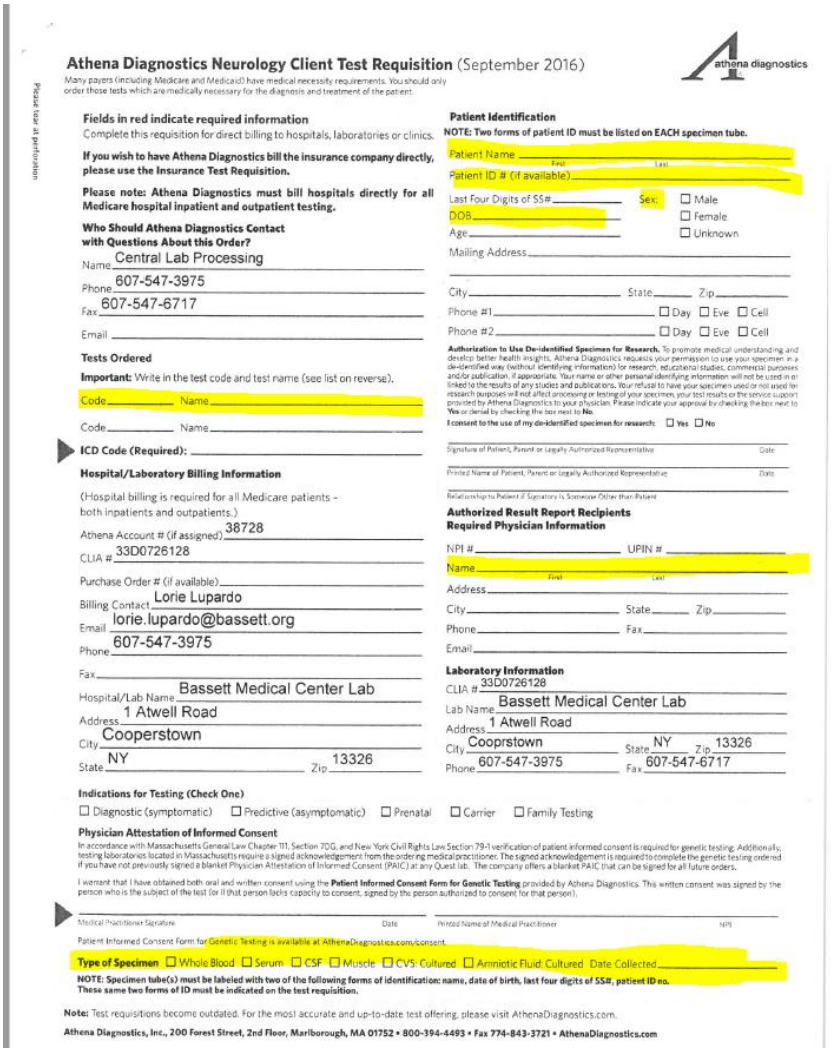
LabCorp

- Process the specimens as necessary for the test(s) being performed.
- Be sure that all testing is ordered properly in the LIS.
- Fill out the appropriate laboratory requisition. Ensure all of the following information is included on the requisition (all are REQUIRED):
    - 2 unique patient identifiers
    - Collection date and time of the specimen
    - Ordering provider information
    - Appropriate tests are check-marked or handwritten on Include performing lab test code.
    - Informed consent has been obtained as necessary
    - If specimen is being sent to LabCorp for insurance reasons mark Insurance Bill
        - Print patient insurance information and send with sample.
- **Make copy of completed requisition to keep on file.**
- Package the specimen appropriately according to the shipping instructions for the test(s) needed.
- **Create an entry in the non-Mayo send out log**
- Contact LabCorp at 800-631-5250 client ID 31513500 to schedule a pick up
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.



Athena, NMS, Viracor-IBT, etc. (sent via UPS)

- Process the specimens as necessary for the test(s) being performed.
- Be sure that all testing is ordered properly in the LIS.
- Fill out the appropriate laboratory requisition. Ensure all of the following information is included on the requisition (all are REQUIRED):
    - 2 unique patient identifiers
    - Collection date and time of the specimen
    - Ordering provider information
    - Appropriate tests are check-marked or handwritten on Include performing lab test code.
    - Informed consent has been obtained as necessary
- **Make copy of completed requisition to keep on file.**
- Package the specimen appropriately according to the shipping instructions for the test(s) needed.
- **Create an entry in the non-Mayo send out log**
- Save a copy of the UPS label in the UPS file
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.



Athena Diagnostics Neurology Client Test Requisition (September 2016)

athena diagnostics

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

Please type or print information

Fields in red indicate required information
Complete this requisition for direct billing to hospitals, laboratories or clinics.

If you wish to have Athena Diagnostics bill the insurance company directly, please use the Insurance Test Requisition.

Please note: Athena Diagnostics must bill hospitals directly for all Medicare hospital inpatient and outpatient testing.

Who Should Athena Diagnostics Contact with Questions About this Order?
Name Central Lab Processing
Phone 607-547-3975
Fax 607-547-6717
Email

Tests Ordered
Important: Write in the test code and test name (see list on reverse).
Code Name
Code Name
ICD Code (Required):

Hospital/Laboratory Billing Information
(Hospital billing is required for all Medicare patients – both inpatients and outpatients.)
Athena Account # (if assigned) 38728
CLIA # 33D0726128
Purchase Order # (if available)
Billing Contact Lorie Lupardo
Email lorie.lupardo@bassett.org
Phone 607-547-3975
Fax
Hospital/Lab Name Bassett Medical Center Lab
Address 1 Atwell Road
City Cooperstown
State NY Zip 13326

Patient Identification
NOTE: Two forms of patient ID must be listed on EACH specimen tube.
Patient Name (First Last)
Patient ID # (if available)
Last Four Digits of SS# Sex: ☐ Male ☐ Female ☐ Unknown
DOB
Age
Mailing Address
City State Zip
Phone #1 ☐ Day ☐ Eve ☐ Cell
Phone #2 ☐ Day ☐ Eve ☐ Cell

Authorization to Use De-identified Specimen for Research. To promote medical understanding and develop better health insights, Athena Diagnostics requests your permission to use your specimen in a de-identified way (without identifying information) for research, educational studies, commercial purposes and/or publication, if appropriate. Your name or other personal identifying information will not be used in or linked to the results of any studies and publications. Your refusal to have your specimen used or not used for research purposes will not affect processing or testing of your specimen, your test results or the service support provided by Athena Diagnostics to your physician. Please indicate your approval by checking the box next to **Yes** or denial by checking the box next to **No**.
I consent to the use of my de-identified specimen for research: ☐ Yes ☐ No
Signature of Patient, Parent or Legally Authorized Representative Date
Printed Name of Patient, Parent or Legally Authorized Representative Date
Relationship to Patient if Signatory is Someone Other than Patient

Authorized Result Report Recipients Required Physician Information
NPI # UPIN #
Name (First Last)
Address
City State Zip
Phone Fax
Email

Laboratory Information
CLIA # 33D0726128
Lab Name Bassett Medical Center Lab
Address 1 Atwell Road
City Cooprstown State NY Zip 13326
Phone 607-547-3975 Fax 607-547-6717

Indications for Testing (Check One)
☐ Diagnostic (symptomatic) ☐ Predictive (asymptomatic) ☐ Prenatal ☐ Carrier ☐ Family Testing

Physician Attestation of Informed Consent
In accordance with Massachusetts General Law Chapter 111, Section 70G, and New York Civil Rights Law Section 79-1 verification of patient informed consent is required for genetic testing. Additionally, testing laboratories located in Massachusetts require a signed acknowledgement from the ordering medical practitioner. The signed acknowledgement is required to complete the genetic testing ordered if you have not previously signed a blanket Physician Attestation of Informed Consent (PAIC) at any Quest lab. The company offers a blanket PAIC that can be signed for all future orders.

I warrant that I have obtained both oral and written consent using the **Patient Informed Consent Form for Genetic Testing** provided by Athena Diagnostics. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person).

Medical Practitioner Signature Date Printed Name of Medical Practitioner NPI

Patient Informed Consent Form for Genetic Testing is available at AthenaDiagnostics.com/consent.

Type of Specimen ☐ Whole Blood ☐ Serum ☐ CSF ☐ Muscle ☐ CVS Cultured ☐ Amniotic Fluid Cultured Date Collected

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must be indicated on the test requisition.

Note: Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit AthenaDiagnostics.com.

Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • 800-394-4493 • Fax 774-843-3721 • AthenaDiagnostics.com

Viracor | Eurofins Clinical Diagnostics

1001 NW Technology Dr. • Lee's Summit, MO • 64086
Viracor-Eurofins.com • Phone: 800-305-5198 • Fax: 816-347-0143

Billing Information	Account #: 3855		
Account Name	Bassett Healthcare		
Contact Name	Brittany Houghton-Depietro	Phone No.	(607) 547-3975
Address 1	1 Atwell Ave		
Address 2			
City	Cooperstown	State NY	Zip 13326

Test Request Form - Hospital/Direct

All Fields are Required. By submitting this order, you certify that this patient or his/her legally authorized representative has provided informed consent for testing and that this consent has been documented in accordance with applicable laws.

Patient Information		Ordering Physician		
Name (Last, First, MI)		Name (Last, First)		
Patient MRN #	Address	Address 1		
☐ Male ☐ Female	City / State / Zip	Address 2		Phone
Birthdate	Phone	City	State	Zip
Hospital Accession #		NPI #	Infection/Organism Expected	

Specimen Information

Date Collected _____/_____/_____ Time Collected _____:_____ ☐ AM ☐ PM Specimen Draw Facility

☐ Abscess Fluid	☐ CSF	☐ Nasal Swab	☐ Plasma	☐ Sputum	☐ Trach Wash
☐ Amniotic Fluid	☐ Eye Swab	☐ Nasal Wash	☐ Pleural Fluid	☐ Synovial Fluid	☐ Urine
☐ Aqueous Fluid	☐ Fecal	☐ NP Aspirate	☐ Rectal Swab	☐ Tissue [Quant. *No liquid and ≥5mg*]	☐ Vitreous Fluid
☐ BAL	☐ Genital Swab	☐ NP Swab	☐ Saliva Swab	☐ Tissue [Qual. *In liquid or <5mg*]	☐ Whole Blood (Test on plasma)
☐ Bone Marrow	☐ Mouth Swab	☐ NP Wash	☐ Serum	☐ Throat Gargle	☐ Whole Blood (Test on whole blood)
☐ Bronch Wash	☐ Nasal Aspirate	☐ Pericardial Fluid	☐ Skin Swab	☐ Trach Aspirate	☐ Wound Swab

Infectious Diseases*

Fungal, Viral, Bacterial, Parasitic

☐403575 16S NGS Bacterial Meningitis

☐7500 Adenovirus qPCR †
☐1600 Aspergillus Galactomannan EIA †
☐8900 Aspergillus Panel PCR (Qual) †
☐5000 Atypical Pneumonia Panel PCR (Qual) †
☐2500 BKV qPCR †
☐2300 BKV IgG Ab
☐3100 Bordetella pertussis Plus PCR (Qual) †
☐5500 CMV qPCR †
☐5600 CMV Resistance: Ganciclovir, Foscarnet, Cidofovir † (Viral Load: _____) (formerly CMV AVR †)
☐30722 CMV Resistance: Letermovir † (Viral Load: _____)
☐30721 CMV Resistance: Letermovir, Ganciclovir, Foscarnet, Cidofovir † (Viral Load: _____)
☐3400 Coccidioides Ab EIA †
☐4500 EBV qPCR †
☐1400 Enterovirus qRT-PCR †‡
☐1700 Fungitell® [1,3]-Beta-D-Glucan †
☐67008 GPP PCR Luminex (10 results)®
☐65008 GPP PCR Luminex (11 results)®
☐68008 GPP PCR Luminex (14 results)®
☐66008 GPP PCR Luminex (15 results)®
☐3700 Histoplasma Antigen EIA †

☐1100 HBV qPCR †
☐1200 HCV qRT-PCR †
☐1300 HCV Genotyping †
☐10000 HCV Genotyping with NS3 Drug Resistance †
☐30600 HCV NS3 Drug Resistance for Genotype 1a †
☐30601 HCV NS3 Drug Resistance for Genotype 1b †
☐30380 HCV Genotyping with NS5A Drug Resistance †
☐30700 HCV NS5A Drug Resistance for Genotype 1a †
☐30701 HCV NS5A Drug Resistance for Genotype 1b †
☐30702 HCV NS5A Drug Resistance for Genotype 2 †
☐30703 HCV NS5A Drug Resistance for Genotype 3 †
☐30381 HCV Genotyping with NS5B Drug Resistance †
☐30500 HCV NS5B Drug Resistance for Genotype 1a †
☐30501 HCV NS5B Drug Resistance for Genotype 1b †
☐30502 HCV NS5B Drug Resistance for Genotype 2 †
☐30503 HCV NS5B Drug Resistance for Genotype 3 †
☐3900 HDV RT-PCR (Qual) †
☐3800 HEV qRT-PCR †
☐6500 HHV-6 qPCR †
☐7000 HHV-7 qPCR †
☐8000 HHV-8 qPCR †‡
☐1800 HIV-1 qRT-PCR †
☐1901 HIV-1 Genotypic Sequencing † (Viral Load: _____)
☐1950 HIV-1 Integrase Genotyping † (Viral Load: _____)

☐8500 HSV 1/HSV 2 qPCR †
☐5916 HTLV I/II PCR (Qual) †
☐3500 JCV qPCR †
☐5400 Legionella Panel PCR (Qual) †
☐3200 Mucorales PCR (Qual)
☐220898 Necrosis Panel TEM-PCR™
☐6800 Nocardia PCR (Qual) †
☐2400 Norovirus RT-PCR (Qual) †
☐1500 Parvovirus B19 qPCR †
☐2000 Pneumocystis jirovecii qPCR †
☐2200 Toxoplasma gondii qPCR †
☐9500 VZV qPCR †
☐4800 Zika Virus RT-PCR (Qual) †

☐30408 Cyclosporine LC-MS/MS †
☐30409 Everolimus LC-MS/MS †
☐4901/4910 Isavuconazole LC-MS/MS †
☐2801/2810 Itraconazole LC-MS/MS †
☐4210 Posaconazole LC-MS/MS †
☐30407 Sirolimus LC-MS/MS †
☐30406 Tacrolimus LC-MS/MS †
☐3301/3310 Voriconazole LC-MS/MS †

Vector-Borne & Serology

☐30290 Babesia duncani WA1 IgG IFA †
☐95325 Babesia microti IgG IFA †
☐401400 Babesia microti IgM and IgG Ab IFA †
☐30150 C6 Borrelia burgdorferi IgG and IgM (Lyme) ELISA †
☐5219239 Dengue IgG †
☐5219229 Dengue IgM †
☐30336 HDV IgM †
☐99202 HDV Total Antibody †

☐99125 HEV IgG †
☐403537 HEV IgG, IgM Panel †
☐99124 HEV IgM †
☐65020 HHV-6 IgG IFA †
☐403918 HHV-6 IgM and IgG Ab IFA †
☐65024 HHV-6 IgM IFA †
☐30294 Zika Virus IgM †

Respiratory Panels

☐220100 Respiratory Viral Panel TEM-PCR™ †‡
☐220200 Respiratory Bacterial Panel TEM-PCR™ †‡
☐220000 Respiratory Pathogen Panel TEM-PCR™ †‡
☐220300 Respiratory Supplemental Panel TEM-PCR™ †‡
☐220600 Influenza/RSV Panel TEM-PCR™ †‡
☐220998 Pharyngitis Panel II TEM-PCR™ †‡
☐220400 Upper Respiratory Panel TEM-PCR™ †‡

Miscellaneous Testing

Test Code	Test Name
☐9000	ImmuKnow® Immune Cell Function Assay †
☐30360	CMV T Cell Immunity Panel †

Test Number	Test Name
_____	_____
_____	_____
_____	_____

Table of Contents

† Tests available for New York samples. See page 8 for further information.

MM 0011 REV37 1218

NMS LABS

ANALYSIS REQUISITION

200 Welsh Road, Horsham, PA 19044-2208
(215) 657-4900 · (866) 522-2206 · Fax: (215) 366-1501
www.nmslabs.com

DO NOT WRITE IN THIS SPACE
RESERVED FOR CLIENT LABEL
(if needed)

Client Profile (Account #): 30603 **Client Name**: Bassett Healthcare Network - Central Lab Process,Cooperstow

Work ID (Patient ID): _____

Sample ID (Patient Name): _____ , _____
Last Name First Name

Date of Birth (mm/dd/yyyy): _____ **Sex**: ☐ Male ☐ Female

Collection Date (mm/dd/yyyy)	**Collection Time** (military)	**Specimen Type*** (matrix)	**Specimen Source** (e.g. CSF, joint)

If sending more than 4 samples, please include the same detail for each sample.

*** If Urine:** ☐ Random ☐ 24 hour (requires volume): Volume: _____ mL

☐ **Return Specimen** (additional charge)

Tests Requested: Please place a check mark next to requested test(s).

____ 0050SP	Acetazolamide, Serum/Plasma	____ 2079B	Fentanyl and Metabolite, Blood
____ 1858B	Drugs of Abuse (10 Panel) and Alcohol Screen,		

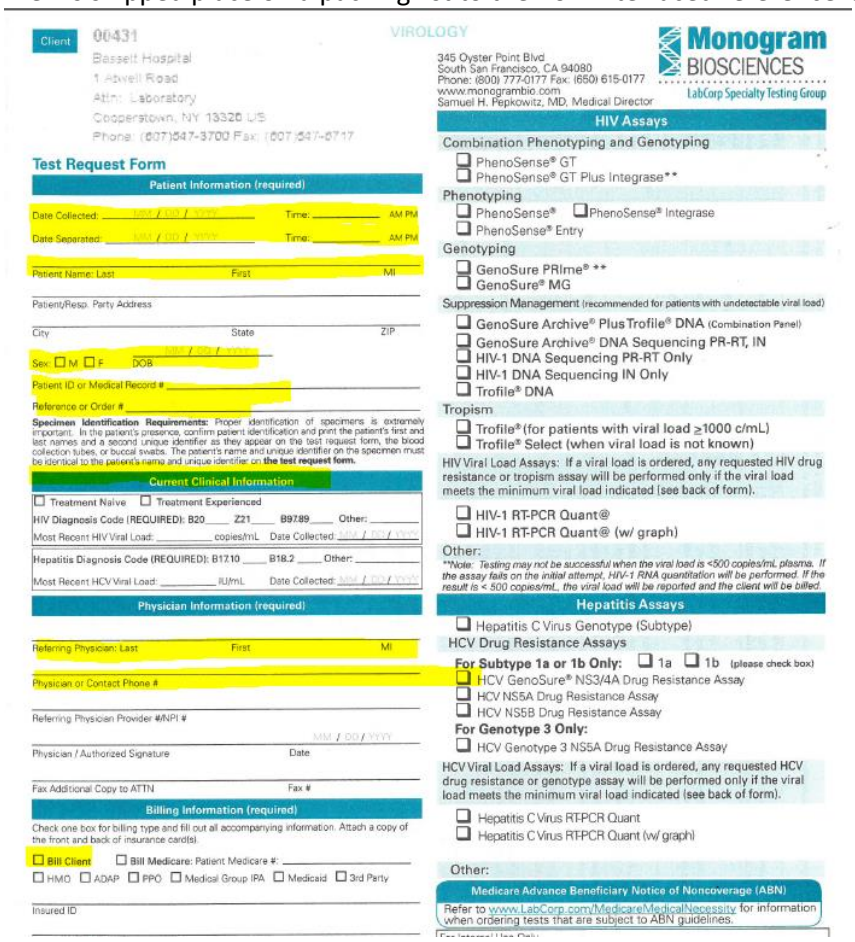
Other Testing:
(The test code and name must be entered. Requisitions submitted without a test code will cause a delay and/or may not be ordered at a time of receipt. If you need assistance, contact our Client Support department at 866.522.2206)

Test Code	Matrix	Test Name	Test Code	Matrix	Test Name

For a complete list of test offerings, visit www.nmslabs.com
If you need assistance, contact us at 866.522.2206

Monogram (sent via LabCorp courier)

- Process the specimens as necessary for the test(s) being performed. Use lab manual to assists with the proper processing of specimens.
- Be sure that all testing is ordered properly in the LIS.
- Fill out the Monogram requisition. Ensure all of the following information is included on the requisition (all are REQUIRED):
    - Date/time collected, date/time processed, patient name, sex, DOB, MRN, accn#
    - HIV diagnosis code (obtained from LIS, ask for help from team leader or manager), HIV viral load (obtained from LIS, look up results from latest HIV viral load)
    - Referring physician, contact info
    - Appropriate test(s) check-marked
- **Make copy of completed requisition to keep on file.**
- Place the specimen(s) into a Monogram specimen bag and place the paperwork in the pocket.
- Store in the black box at the appropriate temperature.
- Contact Monogram Client Services at **1-800-777-0177** to arrange pickup
- **Create an entry in the non-Mayo send out log**
- Once specimen is shipped place on a packing list to the non-interfaced reference lab.



Client 00431
Bassett Hospital
1 Atwell Road
Attn: Laboratory
Cooperstown, NY 13326 US
Phone: (607)547-3700 Fax: (607)547-6717

VIROLOGY

Monogram BIOSCIENCES
LabCorp Specialty Testing Group
345 Oyster Point Blvd
South San Francisco, CA 94080
Phone: (800) 777-0177 Fax: (650) 615-0177
www.monogrambio.com
Samuel H. Pepkowitz, MD, Medical Director

Test Request Form

Patient Information (required)

Date Collected: MM / DD / YYYY Time: AM PM
Date Separated: MM / DD / YYYY Time: AM PM
Patient Name: Last First MI
Patient/Resp. Party Address
City State ZIP
Sex: M F DOB MM / DD / YYYY
Patient ID or Medical Record #
Reference or Order #

Specimen Identification Requirements: Proper identification of specimens is extremely important. In the patient's presence, confirm patient identification and print the patient's first and last names and a second unique identifier as they appear on the test request form, the blood collection tubes, or buccal swabs. The patient's name and unique identifier on the specimen must be identical to the patient's name and unique identifier on **the test request form.**

Current Clinical Information

Treatment Naive Treatment Experienced
HIV Diagnosis Code (REQUIRED): B20 Z21 B97.89 Other:
Most Recent HIV Viral Load: copies/mL Date Collected: MM / DD / YYYY
Hepatitis Diagnosis Code (REQUIRED): B17.10 B18.2 Other:
Most Recent HCV Viral Load: IU/mL Date Collected: MM / DD / YYYY

Physician Information (required)

Referring Physician: Last First MI
Physician or Contact Phone #
Referring Physician Provider #/NPI #
Physician / Authorized Signature Date MM / DD / YYYY
Fax Additional Copy to ATTN Fax #

Billing Information (required)

Check one box for billing type and fill out all accompanying information. Attach a copy of the front and back of insurance card(s).

Bill Client Bill Medicare: Patient Medicare #:
HMO ADAP PPO Medical Group IPA Medicaid 3rd Party
Insured ID

HIV Assays

Combination Phenotyping and Genotyping
PhenoSense® GT
PhenoSense® GT Plus Integrase**
Phenotyping
PhenoSense® PhenoSense® Integrase
PhenoSense® Entry
Genotyping
GenoSure PRIme® **
GenoSure® MG
Suppression Management (recommended for patients with undetectable viral load)
GenoSure Archive® PlusTrofile® DNA (Combination Panel)
GenoSure Archive® DNA Sequencing PR-RT, IN
HIV-1 DNA Sequencing PR-RT Only
HIV-1 DNA Sequencing IN Only
Trofile® DNA
Tropism
Trofile® (for patients with viral load ≥1000 c/mL)
Trofile® Select (when viral load is not known)

HIV Viral Load Assays: If a viral load is ordered, any requested HIV drug resistance or tropism assay will be performed only if the viral load meets the minimum viral load indicated (see back of form).

HIV-1 RT-PCR Quant®
HIV-1 RT-PCR Quant® (w/ graph)
Other:

*Note: Testing may not be successful when the viral load is <500 copies/mL plasma. If the assay fails on the initial attempt, HIV-1 RNA quantitation will be performed. If the result is < 500 copies/mL, the viral load will be reported and the client will be billed.

Hepatitis Assays

Hepatitis C Virus Genotype (Subtype)
HCV Drug Resistance Assays
For Subtype 1a or 1b Only: 1a 1b (please check box)
HCV GenoSure® NS3/4A Drug Resistance Assay
HCV NS5A Drug Resistance Assay
HCV NS5B Drug Resistance Assay
For Genotype 3 Only:
HCV Genotype 3 NS5A Drug Resistance Assay

HCV Viral Load Assays: If a viral load is ordered, any requested HCV drug resistance or genotype assay will be performed only if the viral load meets the minimum viral load indicated (see back of form).

Hepatitis C Virus RT-PCR Quant
Hepatitis C Virus RT-PCR Quant (w/ graph)
Other:

Medicare Advance Beneficiary Notice of Noncoverage (ABN)

Refer to www.LabCorp.com/MedicareMedicalNecessity for information when ordering tests that are subject to ABN guidelines.