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:_____