Date of Request _____

Chart #: _____ Location _____

Patient Name _____

Date of Birth _____

Ordering Provider _____

Diagnosis (ICD 10) _____

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

12/13/22

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

Albany Medical Center Testing

- ☐ HAT: Heparin Antibody Test **STAT**
- ☐ Cyclosporine **STAT**
- ☐ Tacrolimus **STAT**
- ☐ Sirolimus STAT
- ☐ BLPARA- Blood Parasite: Suspected Organism: _____ **STAT**
  (Print out requisition from EPIC and send with this Req and Specimen)
- ☐ Other_____

PLEASE FAX STAT RESULTS TO BASSETT MEDICAL CENTER LABORATORY AT 607-547-5438
Please Call Critical Results to 607-547-3975

AND TO THE ORDERING PROVIDER at: _____

Received By: _____