BASSETT HEALTHCARE NETWORK

Dialysis

Transplant Bloods FORM #18

#6459 (f:\lab\.doc) 1/9/13, 1/23/13,9/7/23,2/16/26

Date of Request Visit Number:

Chart #: Location:

Name Last: First:

Date of Birth Medicaid ID#:

Ordering Provider: _____
Medicaid ID:_____

Attending Provider: _____

SPECIMEN	TIME:	DATE:
COLLECTED BY:		

Please send a separate specimen and requisition for each requesting facility.

Pre-Organ Transplant Screening Sample

☐ Bassett Healthcare Network Dialysis Unit – Bassett Medical Center

☐ Bassett Healthcare Network Dialysis Unit – Little Falls

☐ Bassett Healthcare Network Dialysis Unit – OSS

Destination Transplant Center:

If there is a contact person in the receiving transplant center, please enter that name here: _____

Place facility address here

Lab use only:

Accession Number: _____

Date sent to transplant facility (UPS): _____

Initials: _____

Received by: _____

Top copy to testing facility, 2nd ply to MIB Lab, 3rd ply to be retained in Dialysis