Date of Request Visit Number:

Chart #: Location:

Name Last: First:

Date of Birth Medicaid ID#

Ordering Provider: _____
Medicaid ID:_____

Attending Provider: _____

Please circle requests below. Check box for STAT. Unless indicated, tests are considered "Routine."

BASSETT HEALTHCARE NETWORK
TRANSFUSION / TISSUE/DOWNTIME
LAB TEST REQUEST FORM #3

#4878 (f:\lab\.doc)
1/06,3/06,4/7/06,7/06,1/12/07,4/07,8/1/07,1/14/08,10/6/08,4/6/09,10/5/09,11/16/09,1/4/10 7/19/2010,1/3/11,4/4/11,1/16/12,4/9/12, 7/1/13, 1/6/14, 7/7/14, 10/6/14, 5/14/15.8/4/15.1/17.9/7/23.2/16/26

SPECIMEN	TIME:	DATE:
COLLECTED BY:		
ID CARD -OR- WRISTBANDED		

Diagnosis Code:
or
Descriptive Diagnosis:

PROVIDERS: Compliance is mandatory and regulated. For the laboratory to bill properly and receive payment, you must provide the specific Diagnosis Codes for each outpatient test ordered. Additionally, only tests that are medically necessary for the indicated diagnosis or treatment should be ordered, with supporting documentation in the medical record. Under current Medicare regulations, when certain laboratory tests (indicated by an *) are ordered, and the diagnosis is not listed in the Local Coverage Determination or National Coverage Determinations for that test, payment may be denied. In these cases Medicare requires an Advance Beneficiary Notice (waiver of liability) be signed to allow the hospital to bill the patient. The ABN box on the requisition MUST be checked when an ABN is obtained.

☐ **Patient has signed ABN Waiver (ABN)** ☐ **Patient refused to sign ABN Waiver (ABNR)** ☐ **ABN not required**

BLOOD BANK TESTS

Code	Test Name	STAT
LAB286	Separate and Hold	☐
LAB21083	Cord Blood Hold[5]	☐
LAB276	Type and Screen [1]	☐
LAB21084	Cardiac TSC [2]	☐
LAB274	Direct Antiglobulin Test [3]	☐
LAB21070	Obstetrical Antibody Titer	☐
LAB21071	Infant Group and Rh	☐
LAB21072	Antigen Typing _____	☐
LAB895	ABO/Rh Type Only	☐

TRANSFUSION REACTION WORKUP

LAB893	Transfusion Reaction Workup	☐
LAB21012	Routine Urinalysis [6]	☐

HLA TYPING FOR PLATELET REQUESTS ONLY

LAB21073	HLA A,B Antigen Typing [4]	☐
LAB21074	HLA Cytotoxic Antibody Screen [4]	☐

RHOGAM ORDERS

Code	Test Name	STAT
LAB21075	Antepartum Rhogam (includes TSC)	☐

☐ Micro Dose (12 weeks gestation or less)
☐ Full Dose

Rhogam needed on Date: _____ **Time:**_____ **Location:**_____

LAB21076 PostPartum Rhogam ☐

Infant group and Rh results:
☐ A Positive ☐ O Positive
☐ B Positive ☐ AB Positive

A Fetal Screen is included in a postpartum request for Rhogam. A Fetal Hemoglobin Stain will be performed for any Fetal Screen resulted as positive, invalid or when the baby is Weak D positive for the Rh(D) antigen, to determine the appropriate dose of Rhogam.

CROSSMATCH/ORDER OF BLOOD COMPONENTS

INSTRUCTIONS: Indicate the product that has been ordered by circling the appropriate code and indicating the # of units. RCP orders include a TSC (Type and Screen) and XM (crossmatch). CRCP includes CTS (Cardiac Type and Screen which includes a cold agglutinin screen) and XM (crossmatch). Indicate date, time and location of the planned transfusion for all products ordered. Circle an indication for use and any special requirements necessary for transfusion.

~ STAT ~ URG **Planned Transfusion/Surgery Date:** _____ **Time:** _____ **Location:** _____

Code	Component	# of Units	Code	Component	# of Units	Code	Component
LAB21077	**Red Cell Products**		**LAB21079**	**Platelet Pheresis Products**		**LAB21080**	**Factor Products**

Special Requirements:
1. Autologous
2. Directed
3. CMV Negative
4. Irradiated
5. Split/Aliquot
6. Washed

Indication for use:
1. Active Bleed/Trauma
2. Hgb < 8 or Hct < 25
3. H/H > 8/25 with clinical risk factors
4. H/H > 8/25 ordered by an attending
5. Pre-op scheduled within 48 hours
6. Cardiac Surgery (use CRCP code)
7. Stay Ahead/ Number of Units _____

Special Requirements:
1. CMV Negative
2. Irradiated
3. HLA Matched
4. Crossmatched
5. None

Indication for use:
1. Platelet Count <50,000.
2. Decrease platelet count, invasive procedure
3. Hematology/Oncology MD consulted.
4. Massive Transfusion
5. No platelet count available.

Type of Product
1. Factor VIIa (Novoseven)
2. Factor VIII (Recombinant)
3. Benefix-Factor IX (Recombinant)
4. Other: _____

Other information required:
Date/Location of diagnosed deficiency:
_____
Patient weight: _____ (kgs)
Desired Factor Level (% Activity): _____
Dosage: _____ International Units
Frequency of Dose: _____

Code	Component	# of Units	Code	Component	# of Units
LAB21081	**Plasma Products**		**LAB21082**	**Cryoprecipitate**	

Indication for use:
1. PT/PTT above normal range.
2. Reversal of anti-coagulant therapy.
3. Hematology MD consulted.
4. Invasive procedure.
5. No PT/PTT results available.

Indication for use:
1. Hemophilia A/Factor VIII
2. Hypofibrinogenemia
3. VonWillebrand's Disease

TISSUE PRODUCT

Product: _____
Size/Volume: _____
Quantity: _____

Provider's Signature: _____
Signed Date and Time: _____
Received by: _____

REQUISITIONS Lab

REFLEXIVE TESTING

1. When atypical antibodies are detected, antibody identification studies may be performed.

2. When atypical antibodies are detected, antibody identification studies will be performed. If a nonspecific Cold Agglutinin has been identified, a Cold Agglutinin Titer and Thermal Amplitude Studies will be performed.

3. When DAT is positive due to IgG, eluate study may be performed (only if patient has been pregnant or transfused in past three months).

4. Testing performed by SUNY Upstate Medical University for HLA matched Platelet Requests only.

5. Infant group, RH and DAT will be performed on cord blood specimens collected on RH negative and Type O mothers.

6. A urine sediment examination is performed and billed when RTUA (LAB21012) is ordered and the sample is cloudy or an abnormality is detected.

7. For the Obstetrical Type and Screen received at time of delivery – When atypical antibodies are detected, antibody identification studies will be performed and 4 red cell products will be crossmatched at a minimum with products negative for the corresponding antibody.

8. Testing performed by Albany Medical Center for Fetal Hemoglobin Stain (LAB762) only.