

BLOOD BANK

RUSH UNIVERSITY MEDICAL CENTER
RUSH MEDICAL LABORATORIES
CHICAGO, ILLINOIS 60612 (312) 942-5920
DIRECTOR: MARK POOL, MD

ORDERING PHYSICIAN: _____

DO NOT USE THIS REQUISITION or LABELS EXCEPT FOR EPIC OR LIS DOWNTIME
ORDER THE TYPE AND SCREEN IN EPIC. USE THE LABEL THAT PRINTS ON THE LABEL PRINTER.
Labeling instructions: Use the label that prints on the label printer. Add date and time drawn and initials of phlebotomist and witness. During downtime, use the labels on this requisition, filling in ALL spaces with required information.

One Label Per Tube

One Label Per Tube

Full Name _____ PLACE EPIC LABEL HERE MR# _____ DOB _____	Full Name _____ PLACE EPIC LABEL HERE MR# _____ DOB _____
Date _____ Drawn By _____ Time _____ Witnessed By _____	Date _____ Drawn By _____ Time _____ Witnessed By _____

To order blood products, complete a Transfusion Request in EPIC

PATIENT DIAGNOSIS (MANDATORY) ICD-10 CODE or NARRATIVE RESEARCH PATIENT NOT BILLED TO A FUND #, ENTER V70.7.

NOTE: If federal reimbursement will be sought for the ordered services, physicians must only order those tests that meet Medicare requirements for medical necessity. Medicare generally does not cover routine screening tests.

THIS SECTION TO BE COMPLETED FOR OUTPATIENTS ONLY

BILLING INFORMATION	<input type="checkbox"/> BILL PATIENT	<input type="checkbox"/> BILL INSURANCE	**ATTACH COMPLETED INSURANCE CLAIM FORM TO THIS REQ**				BILLING INFORMATION	
	PATIENT ADDRESS		RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)			SEX <input type="checkbox"/> M <input type="checkbox"/> F		
	CITY	STATE	ZIP CODE	ADDRESS	CITY	STATE		ZIP CODE
	TELEPHONE	SOCIAL SECURITY#		TELEPHONE	DATE OF BIRTH	SOCIAL SECURITY#		
	EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE		
INSURANCE PROVIDER	POLICY/MEMBER#	GROUP#	MEDICARE/MEDICAID# (CIRCLE ONE)		MEDICAID RECIPIENT#			
ORDERING PHYSICIAN			U.P.I.N.					
SEND ADDITIONAL REPORTS TO DOCTOR:			ADDRESS	CITY	STATE	ZIP CODE		
STAT <input type="checkbox"/> ROUTINE <input type="checkbox"/>			CALL STAT RESULTS TO: ()					

IMMUNOHEMATOLOGY STUDIES

Send samples directly to the Blood Bank, 5 Tower Suite 5512 (Tower Tube Station 257 or Four Inch Translogic Tube Station #951)

<p><input type="checkbox"/> TYPE AND SCREEN [GTS] CPT</p> <ul style="list-style-type: none"> • Antibody Screening* 86850 • ABO Type and Rh 86900,89901 <p><input type="checkbox"/> PRENATAL MATERNAL TESTING [GTS]</p> <ul style="list-style-type: none"> • Antibody Screening* 86850 • ABO Type and Rh 86900,89901 • Antibody Titer (if warranted) 86886 (if warranted) <p><input type="checkbox"/> POST-NATAL MATERNAL TESTING [GTS]</p> <ul style="list-style-type: none"> • Antibody Screening* 86850 • ABO Type and Rh 86900,89901 • Fetal Bleed Test (if warranted) 85461 <p><input type="checkbox"/> CORD BLOOD TYPING [GCORD]</p> <ul style="list-style-type: none"> • Direct Antiglobulin Test* 86850 • ABO Type and Rh 86900,89901 <p><input type="checkbox"/> NEONATE TESTING [GNTS]</p> <ul style="list-style-type: none"> • Antibody Screening* 86850 • ABO Type and Rh 86900,89901 <p><input type="checkbox"/> DIRECT ANTIGLOBULIN TEST* [DAT] 86880</p> <p><input type="checkbox"/> AUTOIMMUNE WORK-UP [GTS, DAT]</p> <ul style="list-style-type: none"> • Antibody Screening* 86850 • Direct Antiglobulin Test* 86880x3 <p><input type="checkbox"/> ISOAGGLUTININ TITER [ISO] 86940</p> <p><input type="checkbox"/> COLD AGGLUTININ TITER [COLD] 86940</p>	<p><input type="checkbox"/> AUTOLOGOUS BONE MARROW TRANSPLANT PROFILE [GABMT] CPT</p> <ul style="list-style-type: none"> • ABO Type and Rh <input type="checkbox"/> PRE or <input type="checkbox"/> POST 86900,89901 • Antibody Screening* 86850 • Infectious Disease Profile <input type="checkbox"/> 90 day/1yr follow up <p><input type="checkbox"/> ALLOGENEIC BONE MARROW TRANSPLANT PROFILE</p> <p><input type="checkbox"/> DONOR FOR: _____ [GALOD] <small>Recipient Name/MR#</small></p> <p><input type="checkbox"/> RECIPIENT [GALOR] <input type="checkbox"/> PRE or <input type="checkbox"/> POST</p> <ul style="list-style-type: none"> • ABO Type and Rh 86900,89901 • Antibody Screening* 86850 • Infectious Disease Profile <p><input type="checkbox"/> ADDITIONAL SAMPLE REQUESTS FOR ANTIBODY WORK-UP (three 7-ml EDTA/lavender tubes) [BBEX1] = (1) sample only [BBEX2] = (2) samples [BBEX4] = (4) samples</p> <p><input type="checkbox"/> TRANSFUSION REACTION WORK-UP [POST]</p> <p><input type="checkbox"/> RBC Antigens other than ABO or Rh(D) [BBEX1] 86905 For example: [Kell, Cellano(k), Kidd (Jk^a, Jk^b), Duffy (Fy^a, Fy^b), M, N.]</p> <p><input type="checkbox"/> Rh phenotyping, complete (C,c,E,e) [BBEX1] 86906</p>
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OTHER TESTS: Please print legibly one test per line.

* If antibody screen or direct antiglobulin test is positive, appropriate follow-up test(s) will be performed.