

Shaded areas for Blood Center use only.

**REQUEST
FOR TESTING
Donor Testing
Laboratory**



Puget Sound Blood Center

research | medicine | blood & tissue services

921 Terry Avenue | Seattle, WA 98104-1256

Lab Tech	ID / CL #

Time Received

See back of this order form for sample requirements. Current test descriptions and CPT codes may be viewed at http://www.psbcc.org/lab_virology/

DONOR TESTING LABORATORY (425) 656-7907 Laboratory Staffed for Questions daily, 24 Hrs./Day
Samples accepted daily, 24 Hrs./Day

TESTING PROFILES

Recipient/Patient Battery

Includes: HBsAg, anti-HBc, anti-HCV,
anti-HTLV-I/-II, anti-HIV-1/-2 and STS

Donor Battery

Includes: HBsAg, anti-HBc, anti-HCV, anti-HTLV-I/-II,
anti-HIV-1/-2, STS, anti-T.cruzi and
HCV/HIV/HBV/WNV NAT

INDIVIDUAL TESTS

3060-00 HBsAg

3064-00 anti-HBc

3063-00 anti-HCV

3076-00 anti-HTLV-I/-II

3075-00 anti-HIV-1/-2

3067-00 STS

3070-00 anti-CMV

Screening Test only - do not
perform Confirmatory Testing

3071-01 anti-T.cruzi (Chagas)
(donor samples only)

3077-05/
3077-07/ HCV/HIV/HBV NAT
3078-06 (donor samples only)

3078-08 WNV NAT
(donor samples only)

3075-04 HIV-1/-2 Confirmatory

3076-03 HTLV-I/-II Confirmatory

3063-03 HCV Confirmatory

3078-10 Discriminatory by AmpliScreen

Completion of the Donor Testing Lab Request for Testing (RFT): In addition to the specimen identification, the RFT must contain all the information that is printed **in BOLD font** on the RFT: draw date/time, whether or not sample was frozen, physician or authorized person ordering test, and to whom the report should be sent. Other information on the RFT is optional.

See back of this order form for labeling and sample requirements.

NOTE: Information in **BOLD** must be completed.

Sample Drawn: DATE _____ / _____ / _____ **TIME** _____ am/pm

Sample Drawn By: X _____

Specimen/Accession No.: _____

Physician or Authorized Person Ordering Test:

First _____ **Last** _____

Has sample been previously frozen: Yes No

Diagnosis / ICD9 Code: _____

History / Comments / Special Instructions: _____

Form Completed By: _____

Contact Person: _____ **Name** _____ **Phone Number** _____

If results are needed as soon as available, FAX to:

_____ at (____) _____
Name Fax Number

SEND REPORT TO:

Name _____

Street _____

City, State, Zip _____

SEND BILL TO (if different than above):

Name _____

Street _____

City, State, Zip _____

SPECIMEN IDENTIFICATION:

Name and/or Hospital ID is required in section below. Name/ID must match EXACTLY name/ID on sample label.

Name on Sample <i>LAST</i>	FIRST	M.I.
Hospital Identification Number		
Hospital / Institution		
Sex (M/F)	Date of Birth (mm/dd/yy)	

Labeling Samples: All samples must be properly labeled and information must agree with the identification on the RFT.

- If a specimen is identified by name, there must also be a numeric identifier which may include Hospital number, birth date, or other coded identifier.
- If only a numeric identifier is used (with no name), the number must be a Hospital number or coded identifier. A birth date is not acceptable in this circumstance.
- A draw date should be on the sample but the sample will still be accepted if the draw information is on the RFT.

General Sample Requirements: Complete information on sample requirements (type, volume age and storage requirements), test descriptions, scheduling and reporting can be found at:

- http://www.psbcc.org/lab_virology/

Confirmatory Testing: Confirmatory tests are automatically added to the request and performed at an additional charge if the screening test for HBsAg, anti-HCV, anti-HIV-1/-2, anti-HTLV-I/-II, or T.cruzi is reactive (unless otherwise indicated on the RFT).

For any questions, please call the laboratory (425-656-7907) or visit <http://www.psbcc.org>.

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