



Blood Centers of the Pacific
 Irwin Center, SF
 270 MASONIC AVE., SAN FRANCISCO, CA 94118
 (415) 749-6681 (888) 673-3522 TOLL FREE

REFERENCE LABORATORY TEST REQUEST

CUSTOMER (HOSP/LAB/DR) _____ DATE _____

BILLING ADDRESS _____ P.O. # _____

ATTENDING PHYSICIAN _____

PHONE # _____

PATIENT NAME _____

PATIENT MEDICAL RECORD # _____

SPECIMENS DRAWN: DATE _____ TIME _____

This is not a bill.
 A separate invoice will be sent.

Consultation testing may include serological and/or molecular typing, as indicated.

ATTENTION:

Please submit at least 20-21ml EDTA (purple top) whole blood. Include a pre-transfusion specimen for typing, if available. Patient's sample must be labeled with the patient's first and last name, identification number, date and time the specimen was drawn and the initials/name of the phlebotomist. Specimen labels must match the information on the request form.

SEND SAMPLES TO THE BLOOD CENTERS OF THE PACIFIC - ATTN: REFERENCE LABORATORY.

PATIENT INFORMATION:

RACE _____ DOB _____ ABO/RH _____

CLINICAL DIAGNOSIS _____

MEDICATIONS _____

EVER TRANSFUSED YES NO

PREVIOUS (# AND DATES) _____

MOST RECENT (# AND DATES) _____

PREVIOUS REACTIONS (TYPE) _____

PREGNANCY HISTORY _____

REASON FOR SUBMITTING SAMPLE

- ABO/RH DISCREPANCY
- POSITIVE DIRECT ANTIGLOBULIN TEST
- POSITIVE ANTIBODY SCREEN TECHNIQUE? _____
- INCOMPATIBLE CROSSMATCH

ARE COMPATIBLE RED CELLS NEEDED? _____

HOW MANY? _____ WHEN: _____

SUBMITTED BY: _____ DATE: _____

COMMENTS:

FOR BCP REFERENCE LAB USE ONLY

CPT CODE	TESTS PERFORMED	TRANS CODE	TOTAL
<input type="checkbox"/> 86900	ABO GROUPING	10001	\$ _____
<input type="checkbox"/> 86900/86901	ABO/Rh GROUPING	10000	\$ _____
<input type="checkbox"/> 86978	ADSORPTION AUTO	11395	\$ _____
<input type="checkbox"/> 86978	ADSORPTION ALLO	11396	\$ _____
<input type="checkbox"/> 86978	ADSORPTION RES†	11397	\$ _____
<input type="checkbox"/> 86950	ANTIBODY SCREEN	10025	\$ _____
<input type="checkbox"/> 86972	CELL SEPARATION	10017	\$ _____
<input type="checkbox"/> 86922	COMPATIBILITY TEST	10260	\$ _____
\$ _____	X _____ UNITS		\$ _____
<input type="checkbox"/> 86880	DIRECT ANTIGLOBULIN	10013	\$ _____
<input type="checkbox"/> 86922	DONOR COMPATIBILITY	10200	\$ _____
<input type="checkbox"/> 86903	DONOR NEG FOR AGS:	10202	\$ _____
	ANTIGENS: _____		
\$ _____	X _____ UNITS X _____ AGS		\$ _____
<input type="checkbox"/> 86975	DRUG STUDY	10020	\$ _____
<input type="checkbox"/> 86971	EGA/CHLOROQUINE		\$ _____
<input type="checkbox"/> 86860	ELUTION	11390	\$ _____
<input type="checkbox"/> 86971	ENZYME/DTT		\$ _____
<input type="checkbox"/> 86922	NEUTRALIZATION	10015	\$ _____
<input type="checkbox"/> 86870	RBC IDENTIFICATION PANEL	10010	\$ _____
<input type="checkbox"/> 86870	ADDITIONAL RBC PANEL	10011	\$ _____
<input type="checkbox"/> 86870	RARE CELL PANEL	10012	\$ _____
<input type="checkbox"/> 86865	RBC EXTENDED PHENOTYPE	10206	\$ _____
<input type="checkbox"/> 86906	RH PHENOTYPE (5)	11392	\$ _____
<input type="checkbox"/> 86886	TITRATION	11385	\$ _____
<input type="checkbox"/> 83891/83900/83901/83892/83914/83912	DNA GENOTYPE	10210	\$ _____
<input type="checkbox"/> 86903	HISTORIC AG. NEG	31708	\$ _____
	ANTIGENS: _____		
\$ _____	X _____ UNITS X _____ AGS		\$ _____
<input type="checkbox"/>	AFTER HOURS SURCHARGE	31530	\$ _____
\$ _____	PER HOUR X _____ HOURS		\$ _____
<input type="checkbox"/>	OTHER		\$ _____
TOTAL CHARGE			\$ _____

BCP Technologist _____

Date _____