

HLA LABORATORY

RUSH UNIVERSITY MEDICAL CENTER
 RUSH MEDICAL LABORATORIES
 CHICAGO, ILLINOIS 60612 (312) 942-2378
 DIRECTOR: ROBERT DE CRESCIE, M.D.

ORDERING PHYSICIAN: _____

DATE _____ TIME _____ DRAWN BY _____

DATE _____ TIME _____ DRAWN BY _____

PATIENT DIAGNOSIS (MANDATORY) ICD-10 CODE or NARRATIVE

RESEARCH PATIENT NOT BILLED TO A FUND #, ENTER V70.7.

THIS SECTION TO BE COMPLETED FOR OUTPATIENTS ONLY

BILLING INFORMATION

BILLING INFORMATION

<input type="checkbox"/> BILL PATIENT	<input type="checkbox"/> BILL INSURANCE	**ATTACH COMPLETED INSURANCE CLAIM FORM TO THIS REQ**			
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 ROUTINE CALL STAT RESULTS TO: ()

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.

HISTOCOMPATIBILITY TESTING

SPECIMEN SOURCE: BLOOD BUCCAL SWAB LYMPH NODE SPLEEN

FOR INFORMATION CALL 312-942-8393. ALL TUBES MUST BE LABELED WITH NAME AND D.O.B.

HISTOCOMPATIBILITY TESTS	CPT	HISTOCOMPATIBILITY TESTS	CPT
<input type="checkbox"/> HLA CLASS I & II [LRCOM]	81370	<input type="checkbox"/> HLA ALLO CROSSMATCH [ALLOX]	86805x2
<input type="checkbox"/> HLA CLASS I [LRABC]	81372	<input type="checkbox"/> HLA AUTO CROSSMATCH [AUTOX]	86825x2, 86826
<input type="checkbox"/> HLA CLASS II [LRDRQ]	81375	<input type="checkbox"/> ENDOTHELIAL XM [ENDXM]	86805
<input type="checkbox"/> HIGH RESOLUTION CLASS I & II [HRCOM]	81378	SOLID ORGAN TRANSPLANTATION:	
<input type="checkbox"/> KIR GENOTYPING [DKIR]	81479	<input type="checkbox"/> RECIPIENT [RECSO]	
<input type="checkbox"/> SINGLE ANTIGEN [B27, B51, B57, B58]	81374	<input type="checkbox"/> DONOR [DONSO]	
SPECIFY ANTIGEN _____		<input type="checkbox"/> FOR _____	
<input type="checkbox"/> CELIAC DX [CELI]	81376	<input type="checkbox"/> RELATIONSHIP _____	
<input type="checkbox"/> MICA [MICA]	81479		
<input type="checkbox"/> HLA SOLID PHASE ANTIBODY SCREEN (PRA) [ABSCR]	86828		
IF POSITIVE, SPECIFICITY [SABI/II]	86832, 86833		
<input type="checkbox"/> DSA [DSA]	86832, 86833		

OTHER TESTS: Please print legibly one test per line.