BLOOD BANK

RUSH UNIVERSITY MEDICAL CENTER
RUSH MEDICAL LABORATORIES
CHICAGO, ILLINOIS 60612 (312) 942-5920
DIRECTOR: ROBERT DE CRESCE, M.D.

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

☐ BILL PATIENT ☐ BILL INSURANCE **ATTACH COMPLETED INSURANCE CLAIM FORM TO THIS REQ**

PATIENT ADDRESS			RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)		SEX ☐ M ☐ 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

STATE ☐ ROUTINE ☐ 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)

Test	CPT
❑ **TYPE AND SCREEN** [GTS]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
❑ **PRENATAL MATERNAL TESTING** [GTS]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
• Antibody Titer (if warranted)	86886 (if warranted)
❑ **POST-NATAL MATERNAL TESTING** [GTS]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
• Fetal Bleed Test (if warranted)	85461
❑ **CORD BLOOD TYPING** [GCORD]	
• Direct Antiglobulin Test*	86850
• ABO Type and Rh	86900,89901
❑ **NEONATE TESTING** [GNTS]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
❑ **DIRECT ANTIGLOBULIN TEST*** [DAT]	86880
❑ **AUTOIMMUNE WORK-UP** [GTS, DAT]	
• Antibody Screening*	86850
• Direct Antiglobulin Test*	86880x3
❑ **ISOAGGLUTININ TITER** [ISO]	86940
❑ **COLD AGGLUTININ TITER** [COLD]	86940

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

Test	CPT
❑ **AUTOLOGOUS BONE MARROW TRANSPLANT PROFILE** [GABMT]	
• ABO Type and Rh ❑ PRE or ❑ POST	86900,89901
• Antibody Screening*	86850
• Infectious Disease Profile ❑ 90 day/1yr follow up	
❑ **ALLOGENEIC BONE MARROW TRANSPLANT PROFILE**	
❑ DONOR FOR: ______ (Recipient Name/MR#) [GALOD]	
❑ RECIPIENT [GALOR] ❑ PRE or ❑ POST	
• ABO Type and Rh	86900,89901
• Antibody Screening*	86850
• Infectious Disease Profile	
❑ **ADDITIONAL SAMPLE REQUESTS FOR ANTIBODY WORK-UP** (three 7-ml EDTA/lavender tubes) [BBEX1] = (1) sample only [BBEX2] = (2) samples [BBEX4] = (4) samples	
❑ **TRANSFUSION REACTION WORK-UP** [POST]	
❑ **RBC Antigens other than ABO or Rh(D)** [BBEX1] For example: [Kell, Cellano(k), Kidd (Jk^a, Jk^b), Duffy (Fy^a, Fy^b), M, N.]	86905
❑ **Rh phenotyping, complete (C,c,E,e)** [BBEX1]	86906

OTHER TESTS: Please print legibly one test per line.

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RML FORM NO. 4009
(P.D. 10/19) (10-03-19)