BLOOD BANK

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

ORDERING PHYSICIAN: _____

Full Name _____

ID# _____

One Label Per Tube

DATE _____ DRAWN BY _____

TIME _____ WITNESSED BY _____

Full Name _____

ID# _____

One Label Per Tube

DATE _____ DRAWN BY _____

TIME _____ WITNESSED BY _____

TO ORDER BLOOD PRODUCTS ALSO, COMPLETE A TRANSFUSION REQUEST (FORM #5709). LABEL ALL TUBES WITH PATIENT'S NAME, ID#, DATE & TIME DRAWN, INITIALS OF PHLEBOTOMIST AND WITNESS.

PATIENT DIAGNOSIS (MANDATORY) ICD-9 CODE or NARRATIVE

NOTE: If federal reimbursement will be sought for the ordered services, physicians must only order those tests that meet Medicare requirements for medical necessity.

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#	

BILLING INFORMATION

ORDERING PHYSICIAN | U.P.I.N.

SEND ADDITIONAL REPORTS TO DOCTOR: | ADDRESS | CITY | STATE | ZIP CODE

STAT ☐ ROUTINE ☐ CALL STAT RESULTS TO: ( )

IMMUNOHEMATOLOGY STUDIES

DELIVER SPECIMENS TO 470 JELKE (LSS)

	CPT
❑ **TYPE AND SCREEN** [T/S]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
❑ **PRENATAL MATERNAL TESTING** [T/S]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
• Antibody Titer (If warranted)	86886 (If warranted)
❑ **POST-NATAL MATERNAL TESTING** [T/S]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
❑ **CORD BLOOD TYPING** [CORD]	
• Direct Antiglobulin Test*	86850
• ABO Type and Rh	86900,89901
❑ **NEONATE TESTING** [NEO]	
• Antibody Screening*	86850
• ABO Type and Rh	86900,89901
❑ **DIRECT ANTIGLOBULIN TEST*** [DAT]	86880
❑ **AUTOIMMUNE WORK-UP** [ABSC & DAT, IGDAT, C3DAT]	
• Antibody Screening*	86850
• Direct Antiglobulin Test*	86880x3
❑ **ISOAGGLUTININ TITER** [ISO TITER]	86940
❑ **COLD AGGLUTININ TITER** [COLD]	86940

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

SEND SAMPLES FOR THE FOLLOWING TESTS DIRECTLY TO THE BLOOD CENTER, 262 JELKE

	CPT
❑ **AUTOLOGOUS BONE MARROW TRANSPLANT PROFILE** [AUTO BM]	
• ABO Type and Rh	86900,89901
• Antibody Screening*	86850
• Infectious Disease Profile	
❑ **ALLOGENEIC BONE MARROW TRANSPLANT PROFILE** [ALLO RECIP]	
❑ DONOR FOR: _____ Recipient Name	
❑ RECIPIENT	
• 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)

❑ **TRANSFUSION REACTION WORK-UP**

OTHER TESTS: Please print legibly one test per line

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