ALBANY MEDICAL CENTER
DEPARTMENT OF
LABORATORY MEDICINE

NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208
PH: (518) 262-4549
FAX: (518) 262-8355

AFFIX ARRIVAL LABEL OR COMPLETE BELOW:

NAME: DOB: SEX:

ADDRESS:

SS#: PHYSICIAN:

PRIMARY INSURANCE CO.:

PHLEBOTOMIST INITIALS	DATE COLLECTED	TIME COLLECTED

SUBSCRIBER: RELATIONSHIP TO SUBSCRIBER:

PHYSICIAN SIGNATURE: COPY TO:

ID# GROUP #:

		DIAGNOSIS / ICD9 CODES MANDATORY FOR EACH TEST ORDERED		
STAT				
PHONE		1.	2.	3.
FAX		4.	5.	6.

SECONDARY INSURANCE CO.:

SUBSCRIBER: SUB. DOB: SUB. SEX:

ID#: GROUP #:

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:
MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE
DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE
GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT

BLOOD BANK

FULL PATIENT NAME, DOB, SS#, OR MEDICAL RECORD NUMBER, DATE AND TIME DRAWN, &
PHLEBOTOMIST'S INITIALS ARE REQUIRED ON BOTH THE SPECIMEN AND REQUISITION

TYSCR	☐	∆ TYPE & SCREEN (ABO/RH & AB SCREEN)	7 ML LAV
ABRH	☐	∆ ABO/RH TYPING	7 ML LAV
ABSCR	☐	∆ ANTIBODY SCREEN	7 ML LAV
XM	☐	∆ CROSSMATCH	7 ML LAV

☐ PACKED RED CELLS

_____ MOST RECENT HEMOGLOBIN & HEMATOCRIT

_____ # UNITS

☐ PLATELETS

_____ PLATELET COUNT

_____ # UNITS

☐ PLASMA

_____ PT RESULT

_____ PTT RESULT

_____ # UNITS

SPECIAL ORDERS

☐ CMV SAFE
☐ HEMOGLOBIN S NEGATIVE
☐ LEUKOREDUCED
☐ IRRADIATED
☐ **HOLD 7 ML LAVENDER TUBE FOR HGB & HCT RESULTS**

DATE OF TRANSFUSION _____

TIME OF TRANSFUSION _____

TIME PRODUCT REQUIRED AT SITE _____

95508
(rev 06/03)

∆ =CONFIRMATORY/REFLEX TESTING AT ADDITIONAL CHARGE

THE FOLLOWING INFORMATION IS REQUIRED ON THE SPECIMEN LABEL AND REQUISITION

1. PATIENT NAME, BOTH FIRST AND LAST
2. PATIENT DATE OF BIRTH
3. SOCIAL SECURITY # OR MEDICAL RECORD #
4. COLLECTION DATE AND TIME
5. INITALS OF PERSON COLLECTING THE SPECIMEN

PANEL COMPONENTS

BASIC METABOLIC PANEL	
Sodium	Glucose
Potassium	BUN
Chloride	Creatinine
CO2	Calcium

LIPID PANEL	
Cholesterol	Triglycerides
HDL	Calculated LDL

ELECTROLYTES	
Sodium	Chloride
Potassium	CO2

URINALYSIS	
Specific Gravity	PH
Blood	Glucose
Protein	Bilirubin
Leukocyte Esterase	Ketones
Nitrite	Urobilinogen

COMPREHENSIVE METABOLIC PANEL	
Sodium	Calcium
Potassium	Albumin
Chloride	Alkaline Phosphatase
CO2	ALT (SGPT)
Glucose	AST (SGOT)
BUN	Total Bilirubin
Creatinine	Total Protein

RENAL FUNCTION PANEL	
Sodium	BUN
Potassium	Creatinine
Chloride	Calcium
CO2	Albumin
Glucose	Phosphorous

HEPATIC PANEL	
Albumin	AST (SGOT)
Total Bilirubin	ALT (SGPT)
Direct Bilirubin	Alkaline Phosphatase
Total Protein	

CBC	
WBC	Hemoglobin
RBC	Hematocrit
Indices	Platelet

HEPATITIS PANEL ACUTE	
Hepatitis A Virus Ab IgM	Hepatitis B Surface Ag
Hepatitis B Core Ab IgM	Hepatitis C Ab

OBSTETRIC PANEL	
CBC w/ Auto Diff	Hepatitis B Surface Ag
RPR	Type & Screen
Rubella	

QUAD TEST	
Maternal serum AFP	Unconjugated Estriol
Total Beta HCG	Inhibin A

TRIPLE TEST
Maternal serum AFP
Total Beta HCG
Unconjugated Estriol

Rev. 10/10

REFLEX TESTING WILL BE PERFORMED AT AN ADDITIONAL CHARGE WHEN THE FOLLOWING SERVICES ARE ORDERED:

- CBC WITH AUTOMATED DIFFERENTIAL WITH REFLEX:
  Manual differential will be performed if indicated by automated results
- URINALYSIS WITH REFLEX:
  Urine microscopic will be performed if indicated by dipstick results
- HEPATITIS B SURFACE ANTIGEN
  New positive samples will be confirmed by neutralization
- HEPATITIS B CORE ANTIBODY
  New positive samples will be tested for Hepatitis B Core Antibody IgM
- HEPATITIS A VIRUS ANTIBODY IGG / IGM
  New positive samples will be tested for Hepatitis A virus IgM
- HEPATITIS C ANTIBODY
  Repeatedly weak reactive samples with s/co ratio <3.8 will be reflexed and verified by RIBA (Recombinant Immunoblot Assay) a more specific serologic test. (CDC Recommended)
- ANTIBODY SCREEN
  If positive, Antibody identification will be performed.
- ANTIBODY TITER
  Antibody screen and identification must be performed prior to an Antibody titer.
- DIRECT COOMBS
  If positive, Monospecific coombs (IgG and complement) will be performed. Elution Studies may be indicated if there is a recent history of transfusion.
- COLD AGGLUTININ
  If reactive at room temperature/37°C, Antibody Identification will be performed.
- PLATELET ANTIBODY SCREEN
  If positive, Chloroquine treated Antibody Screen will be performed.
- RPR (VDRL)
  Reactive samples will be reflexed to RPR Titer and to a Treponemal Ab Confirmatory test (NYS requirement)
- HIV 1 / 2
  Reactive/positive samples will be confirmed by HIV-1 Western Blot. If HIV-1 Western Blot is negative or indeterminate an HIV-2 Elisa will be performed. If HIV-2 Elisa is positive an HIV-2 Western Blot will be performed. (NYS Requirement)
- HTLV I/II
  Reactive/positive samples will be confirmed by HTLV-I, HTLV-II Immunoblot (CDC Recommended)
- LYME C6 ANTIBODY
  Positive samples will be confirmed by Western Blot. (no charge) (CDC Recommended)
- Flu A & B RAPID ANTIGEN
  Negative antigen reflexes to viral culture.
- VIRAL CULTURES
  Additional testing may be required for confirmation and/or identification of viruses.
- CULTURES, BACTERIAL
  For proper interpretation of sterile fluid, wound and respiratory cultures, gram stains are routinely performed.
- CULTURES
  Identification and /or susceptibility may be performed dependent on body site and organism isolated.

AEROBIC BLOOD CULTURES ARE ROUTINE, SEE CRITERIA BELOW FOR ANAEROBIC CULTURES
ROUTINE STANDARD OF CARE INDICATES A MINIMUM OF TWO SEPARATE DRAW SITES, AT LEAST 15 MINUTES APART

CONSIDER AEROBIC BLOOD CULTURES IN:
1) New onset of fever, change in pattern of fever or unexplained clinical instability.
2) Hemodynamic instability with or without fever if infection is a possibility.
3) Possible endocarditis or graft infection.
4) Unexplained hyperglycemia or hypotension.
5) To assess cure of bacteremia.
6) Presence of a vascular catheter and clinical instability.

CONSIDER ANAEROBIC BLOOD CULTURES IN:
1) Intra-abdominal infection
2) Sepsis/septic shock from GI site
3) Necrotizing fasciitis or complicated skin/soft tissue infection.
4) Severe oropharyngeal or dental infection.
5) Lung abscess or cavitary lesion.
6) Massive blunt abdominal trauma.

O = ID and /or susceptibility at additional charge if indicated Δ = Confirmatory / reflex testing at additional charge

*BLOOD BANK LABELING - PATIENT'S FULL NAME, MR OR ID#, PHLEBOTOMIST INITIALS, COLLECT DATE & TIME MUST BE ON THE REQUISITION & SPECIMEN OR SPECIMEN WILL BE UNACCEPTABLE FOR ANALYSIS

SPECIMEN / TUBE TYPE KEY			
GRAY = GRAY TOP TUBE	BLAV= 7 ML LAVENDER TOP TUBE (BLOOD BANK ONLY)	WHITE = WHITE TOP TUBE	GRN = GREEN TOP TUBE
BLUE = BLUE TOP TUBE	LAV = LAVENDER TOP TUBE	RED = RED TOP TUBE	YEL = YELLOW TOP TUBE
GLD = GOLD TOP (SST) TUBE	BROWN = BROWN TOP TUBE		

ALBANY MEDICAL CENTER PHLEBOTOMY DRAW SITES

OUTPATIENT BLOOD LAB
43 New Scotland Avenue
M109 (at the PILLARS entrance)
Albany, N.Y. 12208
(518) 262-3548
Hours: Mon-Fri 6:30 AM to 5:00 PM
Saturday 8:30 AM to 12:00 PM

INTERNAL MEDICINE GROUP
1 Pinnacle Place
Albany, N.Y. 12203
(518) 262-2114
Hours: Mon-Fri 7:30 AM – 5:30 PM
Sat 8am – 12pm

ALBANY MED PATIENT SERVICE CTR
2123 River Rd.
Schenectady, N.Y. 12307
(518) 381-6305
Hours: Mon-Thurs 8:30 AM – 5:00 PM
Fri 8:00AM – 4:30PM

LATHAM MED/PED
724 Watervliet Shaker Road
Latham, N.Y. 12210
(518) 262-7651
Hours: Mon-Fri 8:00 AM – 4:30 PM

ALBANY MED PATIENT SERVICE CTR
2 Chelsea Place
Clifton Park, N.Y. 12065
(518) 373-0764
Hours: Mon-Fri 8:30AM – 5:00 PM

SOUTH CLINICAL CAMPUS
25 Hackett Blvd.
Albany, N.Y. 12209
(518) 262-1457
Hours: Mon-Fri 6:30 AM – 4:30 PM