



South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

Patient Billed Client Billed

Blood Bank Testing Requisition

Client Name: _____
 Physician's Last Name, First Name
 [] _____
 [] _____
 [] _____
 [] _____
 [] _____
 [] _____

PATIENT INFORMATION – Please include facesheet

Name _____ Last First MI DOB _____ AGE _____ SEX _____
MM / DD / YYYY

MRN _____ Inpatient Outpatient

ORDERING PROVIDER – Please print name

Fax #: _____

Phone #: _____

SPECIMEN COLLECTION

Date _____ Collector's Initials _____
MM / DD / YYYY

Time: _____ AM PM

STAT Routine

BLOOD BANK / IMMUNOHEMATOLOGY TESTING

Quantity <i>(For SBMF use only)</i>	Test #	Test Name	Quantity <i>(For SBMF use only)</i>	Test #	Test Name
<input type="checkbox"/>	22000	ABO/Rh CPT: 86900; 86901	<input type="checkbox"/>	22007	Eluate ABID CPT: 86860
<input type="checkbox"/>	22014	ABO/Rh Neonate CPT: 86900; 86901	<input type="checkbox"/>	22041	Fetal Screen <i>(positives will be referred to LabCorp for quantitation)</i> CPT: 85461
<input type="checkbox"/>	22008	Antibody Identification CPT: 86870	<input type="checkbox"/>	28032	HDN Antibody Titer CPT: 86886
<input type="checkbox"/>	22306	Antibody Screen CPT: 86850	<input type="checkbox"/>	28031	HDN Antibody Screen CPT: 86850
<input type="checkbox"/>	22470	Antigen Type – Patient CPT: 86905	<input type="checkbox"/>	22004	Rh Blood Type CPT: 86901
<input type="checkbox"/>	22465	Antigen Type – Units CPT: 86902	<input type="checkbox"/>	28089	Rh Immunization Prevention Panel CPT: 86850; 86901
<input type="checkbox"/>	22012	Cardiac Cold Screen CPT: 86850	<input type="checkbox"/>	22051	Rh Phenotype (D, C, c, E, e) CPT: 86906 x5
<input type="checkbox"/>	22461	Crossmatch Screen – XM AHG CPT: 86922	<input type="checkbox"/>	22356	Type and Crossmatch <i>(performed by special arrangement)</i> CPT: 86850; 86900; 86901
<input type="checkbox"/>	22981	Crossmatch Screen – XM IS CPT: 86920	<input type="checkbox"/>	22354	Type and Screen <i>(performed by special arrangement)</i> CPT: 86850; 86900; 86901
<input type="checkbox"/>	20032	Differential DAT (Poly-Ig C3) CPT: 86880 x2	<input type="checkbox"/> Other: _____		
<input type="checkbox"/>	22057	Direct Antiglobulin Test (DAT) CPT: 86880	<input type="checkbox"/> Other: _____		