

Blood Bank Testing Requisition

☐ Patient Billed ☐ Client Billed

Client Name: _____

☒ Physician's Last Name, First Name
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

PATIENT INFORMATION – Please include facesheet

Name _____ DOB _____ AGE _____ SEX _____
 Last First MI 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 (For SBMF use only)	Test #	Test Name	Quantity (For SBMF use only)	Test #	Test Name
	☐ 22014	ABO/Rh Neonate CPT: 86900; 86901		☐ 22004	Rh Blood Type CPT: 86901
	☐ 22000	ABO/Rh CPT: 86900; 86901		☐ 28031	HDN Antibody Screen CPT: 86850
	☐ 22306	Antibody Screen CPT: 86850		☐ 28032	HDN Antibody Titer CPT: 86886
	☐ 22008	Antibody Identification CPT: 86870		☐ 22041	Fetal Screen (positives will be referred to LabCorp for quantitation) CPT: 85461
	☐ 22470	Antigen Type – Patient CPT: 86905		☐ 22051	Rh Phenotype (D, C, c, E, e) CPT: 86906 x5
	☐ 22465	Antigen Type – Units CPT: 86902		☐ 22220	DTT Treatment of RBC
	☐ 22981	Crossmatch Screen – XM IS CPT: 86920		☐ 22354	Type and Screen (performed by special arrangement) CPT: 86850; 86900; 86901
	☐ 22461	Crossmatch Screen – XM AHG CPT: 86922		☐ 22356	Type and Crossmatch # Units _____ (performed by special arrangement) CPT: 86850; 86900; 86901
	☐ 22057	Direct Antiglobulin Test (DAT) - Poly CPT: 86880	☐ Other: _____		
	☐ 20032	Differential DAT (IgG + C3) CPT: 86880 x2	☐ Other: _____		
	☐ 22007	Elution CPT: 86860			