The Christ Hospital Health Network
7450 Mason Montgomery Rd Ste 109 Mason, Ohio 45040
Phone: (513) 648-7900 Fax: (513) 906-5819
Email: SpecialChemistry@thechristhospital.com

Special Chemistry Laboratory Requisition

DONOR IDENTIFICATION INFORMATION

Donor ID		**Date of Birth:**	
Referral #		**Date/Time of Death** (post-mortem only)	
Gender	☐ Male ☐ Female ☐ Other _____	**Additional ID:**	

BILLING INFORMATION

Account	☐ Network for Hope (10301 Linn Station Road, Louisville, KY 40223 Ph:800-525-3456)

SPECIMEN INFORMATION

TUBE TYPE	COLLECTION INFORMATION			TRANSFUSION STATUS	SAMPLE INFORMATION	ADDITIONAL INFORMATION
EDTA **QTY: ___**	DATE: _____ TIME: _____	☐ CST ☐ EST	☐ PST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T
SST **QTY: ___**	DATE: _____ TIME: _____	☐ CST ☐ EST	☐ PST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T
RED **QTY: ___**	DATE: _____ TIME: _____	☐ CST ☐ EST	☐ PST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T
OTHER **QTY: ___**	DATE: _____ TIME: _____	☐ CST ☐ EST	☐ PST ☐ MST	☐ Pre ☐ Post	☐ Living ☐ Pre-Mortem ☐ Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T

TEST PROFILES

☐ **Organ, Stat** (CMV IgG*, CMV IgM*, EBV IgG*, EBV IgM*, HBc Ab Tot, HBs Ag, HCV Ab, HIV Ag/Ab, HIV/HCV/HBV NAT, RPR, Toxo IgG*, Toxo IgM*)

☐ **Tissue, Routine** (HBc Ab Total, HBs Ag, HCV Ab, HIV Ag/Ab, HIV/HCV/HBV NAT, HTLV I/II, RPR)

☐ **Archive Only**

INDIVIDUAL TESTS

CMV IgG (R, S) *	HCV Ab (E, R, S)
CMV IgM (R, S) *	HIV Ag/Ab (E, R, S)
CMV Ab Total (E, R)	HIV/HCV/HBV NAT (E, R, S)
EBV IgG (R, S) *	HTLV I/II (E, R, S)
EBV IgM (R, S) *	RPR (E, R)
HBc Ab IgM (E, R, S) *	Syphilis Ab (E, R)
HBc Ab Total (E, R, S)	Toxo IgG (R, S) *
HBs Ag (E, R, S)	Toxo IgM (R, S) *

KEY: E = EDTA; R = Plain Red Top; S = SST

*** TESTS CANNOT BE RUN ON POST-MORTEM SPECIMENS**

DONOR HISTORY

Please check all known positives:

☐ HBV ☐ HCV ☐ HIV

☐ Other, please specify _____

PROVIDE REPORTS TO:

☐ Cincinnati Eye Bank (Evaluation@cintieb.org)

☐ Eye Bank of Kentucky (EBKYClinicalStaff@ebky.org)

☐ Other, please specify _____

FOR LAB USE ONLY

Labels:

Qualified specimen: ☐ Yes ☐ No Tech: _____ Date: _____