The Christ Hospital Health Network

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 #		**Additional ID:**	
Gender	☐ Male ☐ Female ☐ Other _____	**Priority**: ☐ Stat ☐ Routine	

BILLING INFORMATION

Account	☐ LifeCenter Organ Donor Network (615 Elsinore Pl Ste 400 Cincinnati, OH 45202 Ph: 513-558-5555)

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**
(CMV IgG*, CMV IgM*, EBV IgG*, EBV IgM*, HBc Ab Total, HBs Ag, HCV Ab, HIV Ag/Ab, HIV/HCV/HBV NAT, RPR, Toxo IgG*, Toxo

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

INDIVIDUAL TESTS

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

☐ Archive Only

DONOR HISTORY

Please check all known positives:

☐ HBV
☐ HCV
☐ HIV
☐ Other, please specify _____

KEY: E = EDTA; R = Plain Red Top; S = SST
*** TESTS CANNOT BE RUN ON POST-MORTEM SPECIMENS**

FOR LAB USE ONLY

Labels:

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