REQUEST FOR TESTING
Donor Testing Laboratory

Bloodworks Northwest
701 SW 39th St. | Renton, WA 98057

Time Received

Donor Testing Laboratory: (425) 656-7907 or toll-free (800) 406-4397; Laboratory staffed for questions daily, 24 hrs/day. See back of this form for labeling and sample requirements. Current test descriptions and CPT codes may be viewed at http://www.bloodworksnw.org/lab_virology/

TESTING PROFILES

☐ **Recipient/Patient Battery**
Includes: HBsAg, anti-HBc, anti-HCV, anti-HTLV-I/II, anti-HIV-1/HIV-2, STS

☐ **Donor Battery**
Includes: HBsAg, anti-HBc, anti-HCV, anti-HTLV-I/II, anti-HIV-1/HIV-2, STS, anti-T. cruzi, MPX 2.0 (HCV/HIV/HBV)/WNV NAT

☐ **HCV Reentry**
Includes: anti-HCV, MPX 2.0 NAT

☐ **HIV Reentry**
Includes: anti-HIV-1/HIV-2, MPX 2.0 NAT

☐ **anti-HBc Reentry**
Includes: anti-HBc, HBsAg, MPX 2.0 NAT

INDIVIDUAL TESTS

3060-00 ☐ **HBsAg**
3062-02 ☐ **HBsAg Confirmatory**
3064-00 ☐ **anti-HBc**
3063-00 ☐ **anti-HCV**
3075-00 ☐ **anti-HIV-1/HIV-2**
3075-04 ☐ **HIV-1/HIV-2 Confirmatory**
3076-00 ☐ **anti-HTLV-I/II**
3076-03 ☐ **anti-HTLV-I/II Confirmatory**

3077-05/ 3077-07/ 3078-06 ☐ **MPX 2.0 (HCV/HIV/HBV) NAT** (Donor samples only)
3078-08 ☐ **WNV NAT** (Donor samples only)
3067-00 ☐ **STS** (Standard test for Syphilis)
3070-00 ☐ **anti-CMV**
3071-01 ☐ **anti-T. Cruzi** (Chagas) (Donor samples only)

3078-16 ☐ **EBV VCA IgG**
3078-17 ☐ **EBV NA IgG**
3078-18 ☐ **Toxoplasma IgG**
EBV and Toxoplasma tests are not licensed for blood donor screening

☐ **Screening Test Only** (Do not perform confirmatory testing)

All information in **BOLD** font must be completed.

SPECIMEN IDENTIFICATION
Name and/or Hospital ID is required in section below.
Name/ID must match EXACTLY name/ID on sample label.

Name on Sample *LAST* *FIRST* *M.I.*

Hospital Identification Number

Hospital/Institution

Sex (M/F)	*Date of Birth (mm/dd/yy)*

All information in **BOLD** font must be completed.

Physician or Authorized Person Ordering Test: _____

Sample Drawn: DATE ____/____/____ **TIME** ____ **am/pm**

Sample Drawn By: _____

Has sample been previously frozen: Yes ☐ **No** ☐

Diagnosis/ICD9/ICD10 Code: _____

Internal Use Only *Number and Quality of Specimens Received*	
Specimen Tubes	Specimen Quality
_____ Red Top _____ Lavender Top _____ Other	☐ Accept ☐ Reject

All information in **BOLD** font must be completed.

Contact Person:
_____ (Name) _____ (Phone number)

If results are needed as soon as available, FAX to:
_____ (Name) at _____ (Fax number)

SEND REPORT TO:
Name _____
Street _____
City, State, Zip _____

SEND BILL TO:
Name _____
Street _____
City, State, Zip _____

Form Completed By: _____

Comments:

TO REORDER FORMS CALL (425) 656-3019 or (425) 656-3022
Or reorder by e-mail at forms@bloodworksnw.org

23-9-281 04

BLOODWORKS NW COPY

Labeling Samples: All samples must be properly labeled and information must agree with the identification on the RFT.

- If a specimen is identified by name, there must also be a numeric identifier which may include Hospital number, birth date, or other coded identifier.
- If only a numeric identifier is used (with no name), the number must be a Hospital number or coded identifier. A birth date is not acceptable in this circumstance.
- A draw date should be on the sample but the sample will still be accepted if the draw information is on the RFT.

General Sample Requirements: Complete information on sample requirements (type, volume age and storage requirements), test descriptions, scheduling and reporting can be found at:

- http://www.bloodworksnw.org/lab_virology/

Confirmatory Testing: Confirmatory tests are automatically added to the request and performed at an additional charge if the screening test for HBsAg, Standard Test for Syphilis, anti-HIV-1/HIV-2, anti-HTLV-I/-II, or T.cruzi is reactive (unless otherwise indicated on the RFT).

For any questions, please call the laboratory (425-656-7907, or 800-406-4397) or visit http://www.bloodworksnw.org.

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☐ **anti-HBc Reentry**
Includes: anti-HBc, HBsAg, MPX 2.0 NAT

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3078-06 (Donor samples only)

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