# REQUEST FOR TESTING
# Donor Testing Laboratory

Bloodworks Northwest

701 SW 39th St. | Renton, WA 98057

Time Received

Form 23-9-281

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 https://www.bloodworksnw.org/labs/tests

*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, cobas™ MPX (HCV/HIV/HBV)/WNV NAT

☐ **HCV Reentry**
Includes: anti-HCV, cobas™ MPX NAT

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

☐ **anti-HBc Reentry**
Includes: anti-HBc, HBsAg, cobas™ MPX 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/ ☐ **cobas™ MPX (HCV/HIV/HBV)NAT**
3078-06 (Donor samples only)

3078-08 ☐ **cobas™ WNV NAT** (Donor samples only)

3078-25 ☐ **cobas™ ZIKA 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*

3083-10 ☐ **HLA Screening of Blood Donors For TRALI Mitigation**

☐ **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:
_____ at _____
Name 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