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Special Chemistry Laboratory Requisition

DONOR IDENTIFICATION INFORMATION

Donor ID		Date of Birth
Referral #		Additional ID:
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	Priority: <input type="checkbox"/> Stat <input type="checkbox"/> Routine

BILLING INFORMATION

Account The Cincinnati Eye Bank (4000 Executive Park Drive Suite 420 Cincinnati, OH 45241 Ph: 513-861-3716)

SPECIMEN INFORMATION

TUBE TYPE	COLLECTION INFORMATION	TRANSFUSION STATUS	SAMPLE INFORMATION	ADDITIONAL INFORMATION
EDTA QTY: ____	DATE: _____ TIME: _____ <input type="checkbox"/> CST <input type="checkbox"/> PST <input type="checkbox"/> EST <input type="checkbox"/> MST	<input type="checkbox"/> Pre <input type="checkbox"/> Post	<input type="checkbox"/> Living <input type="checkbox"/> Pre-Mortem <input type="checkbox"/> Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____
SST QTY: ____	DATE: _____ TIME: _____ <input type="checkbox"/> CST <input type="checkbox"/> PST <input type="checkbox"/> EST <input type="checkbox"/> MST	<input type="checkbox"/> Pre <input type="checkbox"/> Post	<input type="checkbox"/> Living <input type="checkbox"/> Pre-Mortem <input type="checkbox"/> Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____
RED QTY: ____	DATE: _____ TIME: _____ <input type="checkbox"/> CST <input type="checkbox"/> PST <input type="checkbox"/> EST <input type="checkbox"/> MST	<input type="checkbox"/> Pre <input type="checkbox"/> Post	<input type="checkbox"/> Living <input type="checkbox"/> Pre-Mortem <input type="checkbox"/> Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____
OTHER QTY: ____	DATE: _____ TIME: _____ <input type="checkbox"/> CST <input type="checkbox"/> PST <input type="checkbox"/> EST <input type="checkbox"/> MST	<input type="checkbox"/> Pre <input type="checkbox"/> Post	<input type="checkbox"/> Living <input type="checkbox"/> Pre-Mortem <input type="checkbox"/> Post-Mortem	Centrifuge: D/T _____ Refrig: D/T _____ Frozen: D/T _____

TEST PROFILES

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

INDIVIDUAL TESTS

- | | |
|--|--|
| <input type="checkbox"/> CMV IgG (R, S) * | <input type="checkbox"/> HCV Ab (E, R, S) |
| <input type="checkbox"/> CMV IgM (R, S) * | <input type="checkbox"/> HIV Ag/Ab (E, R, S) |
| <input type="checkbox"/> CMV Ab Total (E, R) | <input type="checkbox"/> HIV/HCV/HBV NAT (E, R, S) |
| <input type="checkbox"/> EBV IgG (R, S) * | <input type="checkbox"/> HTLV I/II (E, R, S) |
| <input type="checkbox"/> EBV IgM (R, S) * | <input type="checkbox"/> RPR (E, R) |
| <input type="checkbox"/> HBc Ab IgM (E, R, S) * | <input type="checkbox"/> Syphilis Ab (E, R) |
| <input type="checkbox"/> HBc Ab Total (E, R, S) | <input type="checkbox"/> Toxo IgG (R, S) * |
| <input type="checkbox"/> HBs Ag (E, R, S) | <input type="checkbox"/> Toxo IgM (R, S) * |
- Archive Only

DONOR HISTORY

- Please check all known positives:
- HBV
 HCV
 HIV
 Other, please specify _____

PROVIDE REPORTS TO:

- LifeCenter
 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: _____