

**UNIVERSITY OF MISSOURI HEALTH CARE PATHOLOGY
OR TEST REQUEST FORM**

Pathology: STAMP HERE

FORM WILL BE RETURNED AND EXAMINATION DELAYED IF ITEMS IN RED ARE INCOMPLETE

PATIENT LABEL HERE --or-- COMPLETE BELOW Patient name (last, first middle): Date of Birth: Visit (encounter) number: Patient ID#:	CALL BACK NUMBER: OR Room #: OR RN/Person completing form:
--	--

Collection date:	PRIORITY (circle): STAT	Order date:
Collection time:	ROUTINE	Order time:

HISTORY, PHYSICAL FINDINGS, INDICATIONS, ETC.:

PRE-OP DIAGNOSIS: _____ POST-OP DIAGNOSIS: _____
 ICD coded diagnosis: _____

ATTENDING PHYSICIAN (printed) PERFORMING OPERATION/PROCEDURE _____
PRINTED NAME AND SIGNATURE OF STAFF MEMBER FILLING OUT ORDER FORM: _____

LABORATORY ORDERS (DELIVER TO PROCROSSING UNLESS INDICATED)

Specimens delivered to Blood Bank ONLY <input type="checkbox"/> ABORh/ABSC (pink) _____ RBC _____ FFP _____ PLT _____ Cryoprecipitate (Cryo) <input type="checkbox"/> TEG Bleeding (light blue) <input type="checkbox"/> TEG - Heparin (light blue) <input type="checkbox"/> TEG - Platelet Inhibition (dark green)	CHEMISTRY AND HEMATOLOGY <input type="checkbox"/> Basic metabolic panel (BMP)(mint green) <input type="checkbox"/> CBC with Auto Diff (purple) <input type="checkbox"/> CBC without Differential (purple) <input type="checkbox"/> Creatine Kinase (mint green) <input type="checkbox"/> Ionized calcium level (mint green) <input type="checkbox"/> Ionized magnesium (mint green) <input type="checkbox"/> Lactic acid (gray) <input type="checkbox"/> Troponin I (mint green) <input type="checkbox"/> Other Coag <input type="checkbox"/> PT/INR (light blue) <input type="checkbox"/> Fibrinogen (light blue) <input type="checkbox"/> PTT (light blue) <input type="checkbox"/> Thrombin Time (light blue) D- <input type="checkbox"/> <input type="checkbox"/> Dimer (light blue)	CSF: <input type="checkbox"/> Cell Count <input type="checkbox"/> Protein CSF <input type="checkbox"/> Glucose level CSF FLUID OTHER THAN CSF <input type="checkbox"/> Cell Count FLUID (purple top - 1mL) <input type="checkbox"/> Crystals (red top - 1mL) <input type="checkbox"/> Intraop PTH (purple) Time left OR _____ Time Sample given to Lab _____
--	---	---

MICROBIOLOGY (TISSUE OR FLUID IS PREFERRED SPECIMEN) ONE REQUISITION PER SPECIMEN

Specimen number (circle): 1 2 3 4 5 6 7 8 9 10 Specimen Site:

CULTURES

ROUTINE BACTERIAL CULTURE WITH GRAM STAIN (**CHECK ONLY ONE OF THE FOLLOWING TWO OPTIONS**)

Aerobic culture ONLY with susceptibility

Anaerobic/Aerobic culture with susceptibility for aerobes (Must be submitted in anaerobic transport/collection conditions)

FUNGUS CULTURE (Does **NOT** include fungal stain)

ACCEPTABLE SPECIMENS: All Cultures: Tissue in sterile, tightly-closed container, Fluid in capped syringe (needle removed), E-Swab or BBL Swab for Aerobic Bacterial or Fungal Culture

OTHER TESTS

AFB CULTURE AND STAIN (SWABS ARE NOT ACCEPTABLE AND WILL BE REJECTED)

Call Center 884-4522		UH Blood Bank 882-1297
----------------------	--	------------------------