HEMOGLOBIN DIAGNOSTIC REFERENCE LABORATORY

**BOSTON MEDICAL CENTER, BOSTON, MA**

**Specimen Rejection Criteria. Due to improved best practice molecular techniques, specimens >5 days from patient draw will not be eligible to be processed. The test will be cancelled and your laboratory will be notified. Thank you**

* ***Physicians / Clinics / Laboratories who submit specimens to the Boston Medical Center (BMC)***
  + **HEMOGLOBIN DIAGNOSTIC REFERENCE LABORATORY *must agree to reimburse BMC for all charges that pertain to the tests requested.***
* **BMC will invoice your institution, no exceptions.**
* **Invoice statements will include date of service, patient name, CPT codes, test names, and test charges*.***
* **We welcome establishing a memorandum of understanding with your institution.**
* **If you or your finance department has questions regarding these matters, please feel free to contact:**

Gail Whitney at 617-414-4291 or Pamela Medeiros 617-414-7218

Email: <[Gail.Whitney@BMC.org](mailto:Gail.Whitney@BMC.org)> <Pamela.Medeiros@bmc.org>

This form must be signed, and together with the Requisition Form (see page 2), accompany all blood specimens sent to the BMC Hemoglobin Diagnostic Reference Laboratory. Specimen cannot be processed without a fully completed requisition form. **Specimen Rejection Criteria. Due to improved best practice molecular techniques, specimens >5 days from patient draw will not be eligible to be processed. The test will be cancelled and your laboratory will be notified.**

Thank you.

Printed Name \* Signature

**\* By signing this form, you agree to be fully responsible for all charges incurred during blood sample testing.**

Referring Facility Name Date

Referring Facility Address for Billing Purchase Order # if obtained

**Please forward this form, the Requisition form, and blood specimen to:**

**Hemoglobin Diagnostic Reference Laboratory Boston Medical Center**

**670 Albany St. / 3rd Floor Rm. 328**

*Rev.* **04/2022 Boston, MA 02118**

HEMOGLOBIN DIAGNOSTIC REFERENCE LABORATORY REQUISITION FORM

Hemoglobin Diagnostic Reference Laboratory, 670 Albany St, 3rd Floor Rm 328, Boston, MA 02118

Tel.: 617-414-7916; Fax: 617-414-5315; [Email: hemoglobin@bmc.org](mailto:Email:%20hemoglobin@bmc.org%20)

**Specimen Rejection Criteria. Due to improved best practice molecular techniques, specimens >5 days from patient draw will not be eligible to be processed. The test will be cancelled and your laboratory will be notified. Thank you**

Patient Name (Last, First, MI): Date of Blood Draw: Date of Birth: Sex:  M  F MRN:

Patient Address (Please include City, State, Zip Code): **LABORATORY USE ONLY:**

Date Received: HDRL #:

Volume (ML):

Primary Care Physician:

Referring Physician: Hospital/Institution:

Address:

Telephone: Email:

|  |  |
| --- | --- |
| PHYSICIAN ICD-10 DIAGNOSIS  REQUIREMENT NOTICE | When ordering tests, please be informed that the physician (or other authorized individual) is required to make an independent medical necessity decision with regard to each test the laboratory will bill. Additionally, the physician (or other authorized individual) understands he or she is required to (1) submit ICD-10 diagnosis information supported by the patient's medical record, as documentation of the medical necessity of the tests orders or (2) explain and have the patient sign an Advance Beneficiary Notice/Waiver Statement. |
| ICD-10 DIAGNOSIS 1) 2) 3) 4) 5) |

Comprehensive hemoglobinopathy workup Requisition requirement: One requisition per patient

Limited workup. Please specify: Specimen requirement: For adults, send two tubes of EDTA anti-coagulated

Patient's family history:

Provisional Hb diagnosis:

blood (**lavender top**) total of **at least 5mL.of whole blood**. For infants under the age of 2 years, send one pediatric tube.

Patient's Race-Ethnic Background

African American Caucasian Hispanic Other

Patient's medical history: Diagnoses:

Please Specify: Physical findings:

Splenomegaly:

Medications: Hepatomegaly: Other: Pregnancy:

|  |  |
| --- | --- |
| HEMATOLOGY RESULTS  Date: | |
| WBC |  |
| RBC |  |
| HGB |  |
| HCT |  |
| MCV |  |
| MCH |  |
| RDW |  |
| RETIC |  |
| NRBC |  |
| Transfusion history | |
| Red cell morphology | |

|  |  |
| --- | --- |
| HEMOGLOBIN ANALYSIS  Method: | |
| Hb A2 (%) |  |
| Hb F (%) |  |
| Hb A (%) |  |
| Hb Variant (%) Specify (S,C,D,E) |  |
| Hb H (%) |  |
| Newborn Screen |  |
| Heinz Bodies |  |
| Hb H Inclusion bodies |  |
| Hb S Solubility test |  |
| Comments | |

|  |  |
| --- | --- |
| IRON STUDIES / OTHER LABORATORY TESTS | |
| Serum ferritin |  |
| Serum iron |  |
| TIBC |  |
| % Fe Saturation |  |
| Erythropoietin |  |
| G6PD |  |
| Bilirubin |  |
| LD |  |
| Haptoglobin |  |
| Others |  |
| Comments | |

Other Information: 99303 Rev 4/2022