HEMOGLOBIN DIAGNOSTIC REFERENCE LABORATORY

BOSTON MEDICAL CENTER, BOSTON, MA

- ***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.***

- **Within MASSACHUSETTS:**

  For outpatient cases, **BMC will bill third party payers.**

  For inpatient cases, **BMC will bill your institution.**

- **Outside MASSACHUSETTS:** **BMC will bill your institution.**

  A Purchase Order number is required at the time of blood sample testing.

- ***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:**

  Dr. Christopher D. Andry at 617-414-5292.
  Vice Chair for Operations & Management, Department of Pathology.

  or Ms. Marijean Chagnon at 617-638-6132.

This form must be signed, and together with the Requisition Form (see page 3), accompany all blood specimens sent to the BMC Hemoglobin Diagnostic Reference Laboratory. 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 number** ______________________

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

Hemoglobin Diagnostic Reference Laboratory
Evans 248, Boston Medical Center
88 East Newton Street
Boston, MA 02118

Rev. 11/08

DIAGNOSTIC REPERTOIRE

All patients' samples referred to our Laboratory will have the following done:

1. Complete blood counts, unless provided by the referring physician/laboratory.
2. Hemoglobin analysis by high performance liquid chromatography (HPLC), and when necessary by isoelectric focusing (IEF).
3. Genomic DNA extraction.
4. Comprehensive consultation.

COMPREHENSIVE HEMOGLOBINOPATHY WORKUP:

Appropriate DNA-based testing (see below), based upon review by and instructions from the Laboratory Director, in order to arrive at the correct diagnosis.

LIMITED WORKUP:

(1) Common α-thalassemia deletions and/or α-triplications by gap-PCRs.

To diagnose ($-\alpha^{3.7}$); ($-\alpha^{4.2}$); ($--^{SEA}$); ($--^{FIL}$); ($--^{THAI}$); ($--^{MED}$); $-(\alpha)^{20.5}$; ($--^{SA}$).

Also ($\alpha\alpha\alpha^{Anti\text{-}3.7}$); ($\alpha\alpha\alpha^{Anti\text{-}4.2}$) whenever necessary or requested.

(2) β-Globin variant and thalassemia mutations by nucleotide sequencing.

α-Globin variant and thalassemia mutations by nucleotide sequencing.

γ-Globin gene and/or promoter nucleotide sequencing.

δ-Globin variant and thalassemia mutations by nucleotide sequencing.

(3) Hereditary persistence for fetal hemoglobin (HPFH) and δβ-thalassemia deletions, by appropriate gap-PCR's and nucleotide sequencing of globin genes.

PRENATAL DIAGNOSIS:

(1) Both parental mutations are known.

(2) One or both parental mutations not known.

HEMOGLOBIN DIAGNOSTIC REFERENCE LABORATORY

Evans 248, Boston Medical Center, 88 East Newton St., Boston, MA 02118
Tel.: 617-414-1024; Fax: 617-414-1021; Email: hemoglobin@bmc.org Website: http://www.bu.edu/sicklecell/diagnostics.html

Department of Anatomic Pathology

	PATIENT LOCATION Inpatient Outpatient
PRIMARY CARE PHYSICIAN	SPECIMENT COLLECTION DATE
PCP ID NUMBER	SPECIMENT COLLECTED BY
FOR LABORATORY USE ONLY	DATE RECEIVED
HDRL #	VOLUME (ML)

Family Name: Date:

First Name:

MR#

Address:

SS#

DOB:

Telephone: Age: Sex: M F

Referring Physician:

Hospital/Institution:

Address:

Telephone:

Email:

Insurance Carrier:

Subscriber:

Policy Number:

Address:

Additional Insurance Info:

*Please attach copy of insurance card front and back

Note: **All shaded fields are required.**

PHYSICIAN ICD-9 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-9 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-9 DIAGNOSIS 1) 2) 3) 4) 5)

Comprehensive hemoglobinopathy workup

Limited workup. Please specify:

Refer to website for test definitions:
http://www.bu.edu/sicklecell/chui/RequisitionFormAndCharges.pdf

Requisition requirement: One requisition per patient

Specimen requirement: For adults, send two tubes of EDTA anti-coagulated blood (lavender top). For infants under the age of 2 years, send one pediatric tube.

Patient's family history:

Provisional Hb diagnosis:

Patient's medical history:

Diagnoses:

Medications:

Pregnancy:

Patient's Ethnic Background

African American____ Caucasian____ Hispanic____ Other____

Please Specify: ______________________________

Physical findings:

Splenomegaly:

Hepatomegaly: Other:

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

HEMOGLOBIN ANALYSIS Method:	
Hb A_2 (%)	
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: