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> <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
Boston, MA 02118

Rev. **04/2022**

HEMOGLOBIN DIAGNOSTIC REFERENCE LABORATORY REQUISITION FORM

Hemoglobin Diagnostic Reference Laboratory, 670 Albany St, 3rd Floor Rm 328, Boston, MA 02118
Tel.: 617-414-5312; Fax: 617-414-5315; Email: hemoglobin@bmc.org

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

☐ Limited workup. Please specify:

Patient's family history:

Provisional Hb diagnosis:

Patient's medical history:

Diagnoses:

Requisition requirement: One requisition per patient

Specimen requirement: For adults, send two tubes of EDTA anti-coagulated 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____

Please Specify: _____

Physical findings:

Splenomegaly:

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	

Medications: Hepatomegaly: Other:

Pregnancy:

Other Information: