versiti

Cellular Therapy Laboratory

1036 Fuller Ave NE Grand Rapids, MI 49503
Phone (616) 233-8598 Fax (616) 233-8559

INFECTIOUS DISEASE MARKER (IDM) TESTING REQUEST

Fill out this form **COMPLETELY** and send with specimens. See below for specimen handling.

Insert Hospital Label for Specimen or complete:

Name: _____

D.O.B: _____

Medical Record #: _____

- ◯ Autologous patient
- ◯ Allogeneic Recipient
- ◯ Allogeneic Donor (Provide recipient name below)

Recipient Name: _____

IDM Testing Request: ☐ Standard Panel **(No CMV)** ☐ Enhanced Panel **(Includes CMV)**

HEMODILUTION ASSESSMENT:

☐ Individual is 12 years old or younger

Has the patient received any colloidal agent (including blood products) in the 48 hours prior to IDM sample procurement?

- ◯ Yes
- ◯ No

Has the patient received any crystalloid agent in the one hour prior to IDM sample procurement?

- ◯ Yes
- ◯ No

☐ Individual is older than 12 years

Has the patient received more than 2 liters of colloidal agent (including blood products) in the 48 hours prior to IDM sample procurement?

- ◯ Yes
- ◯ No

Has the patient received more than 2 liters of any crystalloid agent in the one hour prior to IDM sample procurement?

- ◯ Yes
- ◯ No

Hemodilution Assessment Performed By: _____ Date: _____

Specimen Sample Collected By:_____ Date: _____ Time: _____

Sample Requirements – Peripheral Blood (Tubes must be full to complete all requested testing)

Adults	**Pediatrics**
1 – 6 ml plain clot tube (no anticoagulant, no gel)	1 – 6 ml plain clot tube (no anticoagulant, no gel)
2 – 6 ml EDTA tubes	1 – 6 ml EDTA tube

Send samples to Versiti at refrigerated temperature (2-8° C) with this form.

Versiti Michigan Use Only:

Date/Time Received: _____