PATIENT TESTING REQUEST FORM

PATIENT PERSONAL INFORMATION

Last Name | **First Name** | **MI**

Street Address | **City**

State | **Zip Code** | **Date of Birth** (- -) | **Sex** M F

Home Phone (- -) | **Business Phone** (- - -) | **Ext.**

Donor ID | **Phleb Review**

PATIENT TYPE

- New Employee
- Post Vaccination
- Employee Blood Exposure
- PRE-Count (Plts)
- Hemoglobin (Hgb)
- HLA Testing
- Other _____
- Donor Reentry
- Donor

DATE & INITIAL ALL TUBES

Sample Date (- -)

Drawn By:

SAMPLE REQUIREMENTS:
1 red (clot) + 3 purple top (EDTA)
EXCEPTIONS:
* Pre Count, Hgb, HLA Testing:
1 purple top (EDTA)

COMMENTS: _____

DIN NUMBER

Date Received (Lab Only)

MEDICAL RELEASE STATEMENT

I do hereby authorize Heartland Blood Centers, 1200 N. Highland Ave, Aurora IL to release test results obtained on my blood sample to the Medical Director or designee.

Signature

Date (- -)