Michigan Blood
MI blood saves lives.℠

STEM CELL LABORATORY

1036 Fuller Ave NE P.O. Box 1704 Grand Rapids, MI 49501-1704 Phone (616) 233-8598 1-866-MIBLOOD Fax (616) 233-8559

INFECTIOUS DISEASE MARKER (IDM) TESTING REQUEST

Fill out this form **COMPLETELY** and send with specimen(s). See below for specimen handling.

Insert Hospital Label for Specimen or complete:

Name: _____

D.O.B: _____

Medical Record #: _____

Specimen Collected By: _____

Date/Time Collected: _____

IDM Testing Request:

☐ **Standard Panel** (Includes CMV)

☐ **Chagas Testing**

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 crystalloid in the one hour prior to IDM sample procurement?

◯ Yes
◯ No

_____
Signature/Date

Sample requirements – peripheral blood:

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

Send sample(s) to Michigan Blood at refrigerated temperature (2-8°C) with this form.

Michigan Blood Use Only:

Date/Time Received: _____