

DEGOWIN BLOOD CENTER REQUISITION

 UI Diagnostic Laboratories
 Department of Pathology
 200 Hawkins Drive, 5231 RCP
 Iowa City, Iowa 52242
 Toll Free: 866-844-2522
 Local: 319-384-7212
 Fax: 319-384-7213

FOR CLIENT USE ONLY: Requisition Date: _____ Completed By: _____ Accn# _____
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FOR UIDL USE ONLY: UIDL Accn # _____ UIDL MRN# _____
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PART A - PATIENT INFORMATION – Required for tests only		
Patient Name: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: () _____		
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Med. Rec. # _____		

PART B - PROVIDER INFORMATION - Required		
Referring Institution: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: _____	Fax: _____	
Referring Physician: _____		
Referring Physician UPIN: _____		

PART C) SPECIMEN INFORMATION AND PATIENT HISTORY- Required		
Date Collected: ____/____/____	Time: _____	Specimen Type: <input type="checkbox"/> EDTA Whole Blood <input type="checkbox"/> Other, Specify: _____
Required ICD-9 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
Does the patient have a history of transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes – Estimated Gestation: _____		
Does the patient have a history of red cell antibodies? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes – Antibody(ies): _____		
Has the patient received Rh(D) in the past three months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Has the patient received IVIG in the past three months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

TEST(S) REQUESTED: REFER TO UIDL TEST DIRECTORY FOR SPECIMEN REQUIREMENTS AND HANDLING INSTRUCTIONS		
<input type="checkbox"/> Blood Type (ABO and Rh)		
<input type="checkbox"/> Antibody Screen		
<input type="checkbox"/> Antibody Identification and Clinical Pathology Consultation (Note: Antibody Identification may require extensive testing necessary to interpret antibody)		
<input type="checkbox"/> Antibody Titration (IgG with Marsh Score), Specify Antibody: _____		
<input type="checkbox"/> Antibody Titration (IgM + IgG), Specify Antibody: _____		
<input type="checkbox"/> Direct Antiglobulin Test (DAT)		
<input type="checkbox"/> Fetal Red Cell Screen		
<input type="checkbox"/> Platelet Antibody Screen and Clinical Pathology Consultation		
<input type="checkbox"/> RBC Antigen Testing, Specify Antigen: _____		
<input type="checkbox"/> Other (Specify): _____		

REFER TO UIDL [TEST DIRECTORY](#) FOR SPECIMEN REQUIREMENTS AND HANDLING INSTRUCTIONS

PART D - SEND BILL TO: (Required)	<input type="checkbox"/> Referring Institution : Contact _____ Address, City, State, Zip: _____ <input type="checkbox"/> Patient's Insurance (Complete billing information must be provided or referring institution may be billed) (Required information is in red)
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Please note that the **correct birth date of all policy holders** is required information. Please attach the following to the requisition:

(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.
OR
 (2) a printout with patient demographics and insurance information from your practice management system.
 Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.