Request Forms/Forms

Anatomic Pathology Request Form

Your resource for life.
MaineGeneral Medical Center

ANATOMIC PATHOLOGY REQUISITION

Pathology Associates

Augusta & Waterville, Maine

J. Benziger, W. Kindig, R. Metzman, J. Oprendek & C. Saunders -Pathologists

CASE NUMBER

Date Submitted	Date Received

Physician

Patient Location

❑ Physician Office

Out-Patient Augusta Waterville

In-Patient Augusta Waterville

Room#

EXAMS REQUIRED

- ❑ Tissue for Surgical Pathology Exam
  - ❑ Gross Only Exam
- ❑ Frozen Section/Intra-operative Consult
- ❑ Aspiration Fluid/Biopsy for Cytology Exam
- ❑ Body Fluid for Cytology Exam
- ❑ Bone Marrow Aspiration/Biopsy

PATIENT INFORMATION

Last Name	First Name	Sex Male Female	Date of Birth

Street Address Town/Zip Code

Insurance Carrier Policy Number

SPECIMEN TYPE AND SITE

1

2

3

4

5

6

7

CLINICAL HISTORY

Please provide as much information as possible.

Pre-op/Working Diagnosis

Operation/Procedure Performed

Post-op Diagnosis/Questions/Comments

Frozen Section/Intra-operative Consult Diagnosis

Lab use only please

Pathologist:

❑ 88312 (Thiazine)	❑ 88302 (MicroID)	❑ 88305 (Micro)	❑ 88311 (Decal)	❑ 85097 (Bone Marrow)
❑ 88300 (Gross Only)	❑ 88304 (Micro)	❑ 88306 (Asp Biopsy)	❑ 88307 (Micro)	❑ 88331 (Frozen Section)
			❑ 89309 (Micro)	❑ 88332 (Add Frozen)

White Copy - Laboratory Yellow Copy -Billing

Stock Form # 320-1415 revised 1/05

Blood Lead Reporting Form (Front)

Health and Environmental Testing Laboratory

221 State Street, SHS 12
Augusta, Maine 04333
telephone:207-287-2727 / fax:207-287-8925 / web:maine.gov/dhhs/etl

Maine Department of Health and Human Services
Maine CDC
Maine Center for Disease Control and Prevention

Submitter Name Address/Phone	Hospital/Lab ID#	Submitter Fax Number
MAINEGENERAL MEDICAL CENTER LABORATORY 149 NORTH STREET WATERVILLE, MAINE 04901 PHONE (207) 872 1159 FAX (207) 872 1157	Physician Name	Physician Practice/Affiliation

Patient Name: Last	First	M.I.	Gender: M F	Specimen Type/Source
			Date of Birth: / /	Specimen Collection Date

Below required for Blood Lead, Reportable Diseases, or MaineCare Primary Insurance

Patient Street Address	Apt. #	City/Town	State	Zip	County

Race	Ethnicity	MaineCare # (if primary) (Please include copy of MaineCare card)	Parent/Guardian Name: Blood Lead
[ ] American Indian or Alaskan Native [ ] Asian [ ] Black or African-American [ ] Native Hawaiian/Pacific Islander [ ] White	[ ] Hispanic or Latino [ ] Non-Hispanic/Non-Latino	[ ] Code 1 Blood Lead (if applicable)	Parent/Guardian Phone Number: Blood Lead

Please see reverse of this form for information on specimen type, storage and shipping conditions.
Specimens MUST be labeled with patient name and Date of Birth.

BACTERIOLOGY

- [ ] Chlamydia/Gonorrhea (amplified probe)
- [ ] *Bordetella pertussis*
- [ ] *Campylobacter* Identification
- [ ] *E. coli* Identification/serotyping
- [ ] Enteric pathogen screen (*Salmonella*, *Shigella*, *Campylobacter*)
- [ ] *Neisseria gonorrhoeae* confirmation
- [ ] *Neisseria meningitides* grouping
- [ ] *Salmonella* Identification/serotyping
- [ ] Shiga Toxin Test
- [ ] *Shigella* Identification/serotyping
- [ ] *Vibrio* Identification
- [ ] *Yersinia* Identification
- [ ] Reference Culture, Identification

Organism Suspected:

Please attach previous test results

BLOOD LEAD

- [ ] Blood Lead, Venous
- [ ] Blood Lead, Capillary
- [ ] Check if Symptomatic or Repeat Test

SEROLOGY

- [ ] Arbovirus IgM Panel (West Nile, EEE, SLE, Powassan) (requires MECDC surveillance form)
- [ ] Cryptococcus Antigen
- [ ] Anti-Hepatitis B surface antigen; IgG
- [ ] Hepatitis C IgG
- [ ] HIV-1/HIV-2 screen (serum)
- [ ] HIV-1/HIV-2 screen (oral fluid)
- [ ] Mumps IgG
- [ ] Rubella IgG
- [ ] Rubeola IgG
- [ ] RPR syphilis screen
- [ ] Syphilis serum confirmation
- [ ] Syphilis spinal fluid VDRL
- [ ] Varicella zoster IgG

MYCOBACTERIOLOGY

- [ ] Acid fast smear/culture
- [ ] Acid fast smear
- [ ] MTD Amplified Probe (smear Positive only)
- [ ] Reference Culture, Identification

MYCOLOGY

- [ ] Mycology, Clinical Specimens
- [ ] Reference Culture, Identification

VIROLOGY

- [ ] Influenza A/B RT-PCR
- [ ] Mumps RT-PCR
- [ ] Norovirus RT-PCR
- [ ] Varicella/Herpes zoster PCR
- [ ] Herpes Simplex (HSV 1/2) PCR
  - [ ] Viral Culture reflex for PCR test selected above (see reverse)
- [ ] Viral Culture, Routine (10 days)
  - [ ] add CMV (21 days)

Other tests/
Additional Information:

Maine CDC
Outbreak Investigation ID# :

Investigator :

rev. 10/07

Blood Lead Reporting Form (Back)

For questions about a disease outbreak or notifiable conditions, please call

Maine CDC- Disease Reporting

HOW TO REPORT:

TELEPHONE: 1-800-821-5821 (24 hours a day) OR **FAX: 1-800-293-7534 (24 hours a day)**

Influenza A/H5 Testing

Consult with Infectious Disease Epidemiology – Maine CDC

1-800-821-5821

As soon as a suspect/possible case has been identified

- For direction on whether a patient should be tested
- For infection control measures
- For information on current sampling guidelines and specimen transport
- For immediate coordination with laboratory

For a full test catalog, specific specimen collection instructions, test kit order forms, arboviral surveillance forms and an electronic version of this requisition form, please visit:
www.maine.gov/dhhs/etl/micro

Reportable Diseases Requiring Submission to HETL:

Bordetella pertussis
Clostridium botulinum
Clostridium tetani
Corynebacterium diphtheria
Escherichia coli 0157:H7
Escherichia coli – shiga toxin producing – all serotypes
Francisella species
Haemophilus influenzae, invasive
Legionella species
Listeria species
Mycobacterium species (TB complex only)
Neisseria meningitidis
Novel Influenza
Salmonella species, including *S. typhi*
Shigella species
Vibrio species
Yersinia pestis
For a full list of Notifiable Conditions, please visit:
http://www.maine.gov/dhhs/boh/ddc/disease_reporting.htm

Category 1 Diseases that are possible indicators of bioterrorism:

Anthrax
Botulism
Brucellosis
Gram positive rod septicemia or meningitis, growth within 72 hours
Outbreaks of unusual disease or illness
Plague
Q fever
Ricin Poisoning
Smallpox
Staphylococcal enterotoxin B pulmonary poisoning
Tularemia
Venezuelan equine encephalitis

Specimen types, storage and shipping conditions:

- General test kits are available from HETL for Virology, Serology and Mycobacteriology.
- Specific test kits are available for Blood Lead, *B. pertussis* (culture and/or PCR), HIV oral fluid and Chlamydia/Gonorrhea amplified probe testing.
- Test kits include sampling materials and instructions as well as packing materials and shipping containers for couriers or US Mail. To order test kits please call 207-287-2727 or fax order to 207-287-6832

MYCOLOGY

- Submit clinical specimens (hair, nail clippings, tissue, body fluids) in sterile containers

VIROLOGY

- Collect specimens promptly (within 1-3 days of onset ideally)
- Use polyester/dacron swabs and viral transport medium
- Urine or stool specimens should be sent in sterile, leak proof containers.
- **Store specimens at refrigerator temp. and ship on frozen gel packs**
- Do not freeze specimens , Do not ship on dry ice
- Specific instructions for specimen collection available at www.maine.gov/dhhs/etl/micro
- Viral Culture Reflex Test for PCR: if selected PCR test is negative, routine culture will be ordered to detect other viruses

SEROLOGY

- Blood should be collected without anticoagulants or preservatives
- 5ml for an adult or 3ml for pediatric patients is sufficient volume
- Do not freeze blood specimens
- It is best to physically separate serum from the blood clot within 24 hours
- HIV confirmation is automatically ordered for HIV+ screens

MYCOBACTERIOLOGY

- 5ml is the recommended minimum sample volume for AFB recovery
- Respiratory specimens and other body fluids - collect in sterile container
- Bone marrow and blood - collect in heparin (green top) tube
- Tissue biopsy and bone - collect in sterile container with 1-2ml dH_2O or saline
- Urine – collect first morning in sterile container shipped on ice

BACTERIOLOGY

- Chlamydia/Gonorrhea amplified probe test: urine and swab specimens from both male and female patients are acceptable. GenProbe collection tubes are REQUIRED for this test (available from HETL – call 207-287-2727)
- *B. pertussis* PCR and culture sampling instructions available at www.maine.gov/dhhs/etl/micro
- Shiga toxin positive broths should be sent for confirmation and serotyping
- Isolates sent for identification should include prior lab results

BLOOD LEAD

- Minimum of 300ul whole blood
- Heparin (green top) or EDTA (purple top) tubes are acceptable
- Sodium Citrate (light blue top) is **NOT** acceptable
- Capillary specimens with high levels will require venous confirmation

Cervical Cytology "PAP" Request Form

Your resource for life.
MaineGeneral Medical Center

CERVICAL CYTOLOGY "PAP" REQUISITION

Pathology Associates, Augusta – Waterville
C. Aubertine, J. Benziger, R. Metzman, J. Oprendek & C. Saunders - Pathologists

CASE NUMBER	
DATE SUBMITTED	DATE RECEIVED
PHYSICIAN	
PATIENT LOCATION ❑ PHYSICIANS OFFICE IN PATIENT AUG WTVL	

LAST NAME	FIRST NAME	DATE OF BIRTH	FEMALE ❑	MALE ❑
STREET ADDRESS		TOWN/ZIP CODE		
TELEPHONE #	SOCIAL SECURITY #	PREVIOUS LAST NAME		
INSURANCE PROVIDER		POLICY NUMBER / GROUP		
INSURANCE PROVIDER ADDRESS				

SPECIMEN
- ❑ Sure Path PREP cell suspension vial
- ❑ Conventional Smear

SOURCE
- ❑ Cervical - Endocervical
- ❑ Vaginal

HPV TESTING
- ❑ Reflex Testing
  For Pap with ASCUS (Atypical Squamous cells of uncertain significance) For women over 21 only
- ❑ Pap plus HPV For women over 30 only

For HPV Testing without Pap use Digene collection device (not Sure Path vial) and send to clinical lab

SPECIMEN ADEQUACY
- ❑ Satisfactory Endocervical cells Present
- ❑ Satisfactory Endocervical cells Absent
- ❑ Satisfactory
- ❑ Unsatisfactory:_____

DIAGNOSTIC CATEGORY
- ❑ Negative for intrapithelial lesion or malignancy
- ❑ Epithelial Cell Abnormality

DIAGNOSIS
- ❑ Infection
  - ❑ Candida species
  - ❑ Predominance of coccobacilli
  - ❑ Other _____
- ❑ Reactive/Reparative Changes
- ❑ ASCUS (Atypical squamous cells of uncertain significance)
- ❑ LGSIL (Low grade squamous intraepithelial lesion)
- ❑ HGSIL (High grade squamous intraepithelial lesion)
- ❑ Other_____

CLINICAL HISTORY
Date of LMP_____
- ❑ Pregnant
- ❑ Post Partum
- ❑ Post Menopausal since_____
- ❑ Prior Hysterectomy in _____

Date of last Pap Smear _____
- ❑ Previous abnormal Pap Smear or Biopsy
  Date_____
  Diagnosis _____
- ❑ Vaginal Discharge
- ❑ Dysfunctional Uterine Bleeding
- ❑ Abnormal Post Menopausal Bleeding
- ❑ Current hormone therapy of _____
- ❑ Intra-Uterine Device
- ❑ Prior Radiation Therapy
- ❑ Other History/Comments _____

CYTOTECH _____ ❑ Agree PATHOLOGIST_____
❑ Changes marked

Cervical Cytology is billed by **The Pathology Associates**
through Laboratory Billing Services
4 Scammon Street, Suite 19, PMB 2700
Saco, Maine 04072-1480
Telephone (800) 286-4684

MEDICARE WAIVER OF LIABILITY ADVANCE NOTICE OF NON-COVERAGE FOR PAP SMEAR SCREENING

Medicare will only pay for services it determines to be 'reasonable and necessary' under section 1862 (a)(1) of the Medicare Law. Current Medicare program standards allow payment for only one routine pap smear every two years. We believe that, in your case, Medicare is likely to deny payment for that reason.

I have been notified by The Pathology Associates that it is possible that MEDICARE WILL DENY PAYMENT FOR MY PAP SMEAR for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

White - Billing Copy Yellow - Pathology Copy Pink - Office Copy

_____ *Date of Service*

_____ *Patient Signature*

Stock Form #320-1407 Rev. 1-08

General Request Form (Front)

MaineGeneral Medical Center

149 North Street
Waterville, Me 04901
Tel: (207) 872-1159 Fax: (207) 872-1339

325 B Kennedy Memorial Drive
Waterville, Me 04901
(207) 872-4300 Fax: (207) 877-8161

6 East Chestnut Street
Augusta, Me 04330
Tel: (207) 626-1400 Fax: (207) 626-1143

Name (Last, First, MI) _____

D.O.B._____Sex: M / F SS# _____

Legal guardian if Patient a Minor_____

Mailing Address _____

_____Phone:_____

City_____State_____ Zip_____

Insurance Subscriber:_____

Subscriber's Place of Employment_____

INSURANCE GROUP # CERT-SSN

_____

Claim Address:_____

_____

Claim Address: _____

_____

Primary Care Physician _____

Health Agency/Nursing Home _____

Ordering Provider (Please Print) _____

To PREREGISTER CALL (207) 626-1583 OR 1-800-343-3400

Provider's Signature REQUIRED _____

Copy to_____

MGMC Account # _____ A / W

Priority:

___ **STAT**
___ Routine
___ Preop

Specimen Collection:

Date: _____

Time: _____

Date_____ Initials:_____

When ordering tests for which Medicare or Medicaid reimbursement will be sought, providers should only order tests that are MEDICALLY NECESSARY for the diagnosis or treatment of the patient, rather than for screening purposes.

REASON FOR TEST (SIGNS/SYMPTOMS):

KEY: **R**=REFLEX TESTING — SEE REVERSE SIDE *BOLD=TEST MAY REQUIRE ADVANCED BENEFICIARY NOTICE

MEDICARE APPROVED PANELS

- ☐ **ACUTE HEPATITIS PANEL***
- ☐ BASIC METABOLIC PANEL
- ☐ COMPREHENSIVE METABOLIC PANEL
- ☐ ELECTROLYTES
- ☐ **GENERAL HEALTH PANEL***
- ☐ HEPATIC FUNCTION PANEL(LIVER GRP)
- ☐ **LIPID PANEL/CARD RISK***
- ☐ **PRENATAL PANEL***
- ☐ RENAL FUNCTION PANEL

INDIVIDUAL TESTS

- ☐ **AFP***
- ☐ ALBUMIN
- ☐ ALK PHOS
- ☐ AMYLASE
- ☐ ASOT
- ☐ DIRECT LDL
- ☐ BILIRUBIN, DIRECT
- ☐ BILIRUBIN, TOTAL
- ☐ BLEEDING TIME
- ☐ BUN
- ☐ C-REACTIVE PROTEIN
- ☐ **CA-125***
- ☐ CALCIUM
- ☐ CARBAMAZEPINE (TEGRETOL)
- ☐ **CBC, DIFF, PLATELET COUNT* R**
- ☐ **CBC, PLATELET COUNT***
- ☐ **CEA***
- ☐ **CHOLESTEROL***
- ☐ CO_2 CONTENT
- ☐ CREATININE
- ☐ **DIGOXIN* (LANOXIN)**
- ☐ **LIPID W/REFLEX TO DLDL**
- ☐ **CHOL W/REFLEX TO LIPID**

INDIVIDUAL TESTS continued

- ☐ ELECTROPHORESIS (S/U) **R**
- ☐ ESR (SED RATE)
- ☐ ESTROGEN
- ☐ **FERRITIN***
- ☐ FOLATE
- ☐ FSH
- ☐ **GGTP***
- ☐ **GLUCOSE***
- ☐ GLUCOSE PREGNANCY SCRN (50 grm.)
- ☐ **GLYCO HEMOGLOBIN (A1C)***
- ☐ H.PYLORI ANTIBODY
- ☐ **HCG. BETA SUB UNIT***
- ☐ **HEMATOCRIT***
- ☐ **HEMOGLOBIN***
- ☐ SEMEN ANALYSIS-POST VAS
- ☐ SEMEN ANALYSIS-INFERTILITY
- ☐ ZINC
- ☐ CHROMIUM
- ☐ **HGB AND HCT***
- ☐ **HIV (SIGNED CONSENT FORM REQUIRED)***
- ☐ **IRON***
- ☐ **IBC/% SATURATION***
- ☐ LDH, TOTAL
- ☐ LEAD
- ☐ LH
- ☐ LIPASE
- ☐ LITHIUM
- ☐ MAGNESIUM
- ☐ MONOSPOT
- ☐ **OCCULT BLOOD***
- ☐ PHENOBARBITAL
- ☐ PHENYTOIN (DILANTIN)
- ☐ PARATHYROID HORMONE (PTH)

INDIVIDUAL TESTS continued

- ☐ **PLATELET COUNT***
- ☐ POTASSIUM
- ☐ PREGNANCY TEST, URINE
- ☐ PROGESTERONE
- ☐ PROLACTIN
- ☐ PROTEIN TOTAL - (BLOOD)
- ☐ PROTEIN - 24HR URINE
- ☐ **PSA – Diagnostic***
- ☐ **PSA SCREEN FOR PROSTATE CA**
- ☐ **PT with INR***
- ☐ **PTT***
- ☐ **RETIC COUNT***
- ☐ SELENIUM
- ☐ SGOT (AST)
- ☐ SGPT (ALT)
- ☐ **T3, FREE***
- ☐ **T4, FREE***
- ☐ TESTOSTERONE
- ☐ THEOPHYLLINE
- ☐ TRANSFERRIN
- ☐ TRIGLYCERIDE
- ☐ **TSH***
- ☐ **TSH W/REFLEX***
- ☐ URIC ACID
- ☐ URINALYSIS no MICROSCOPIC
- ☐ URINALYSIS with MICROSCOPIC
- ☐ **URINE CULTURE IF INDICATED* R**
- ☐ VALPROIC ACID (DEPAKOTE)

Other Test (s):

- ☐ _____
- ☐ _____
- ☐ _____

MICROBIOLOGY

SOURCE_____

- ☐ AFB (TB) Smear & Culture
- ☐ BETA STREP GROUP A RAPID ANTIGEN SCREEN
- ☐ C. DIFFICILE
- ☐ CHLAMYDIA PROBE
- ☐ CHLAMYDIA & GONORRHEA PROBES
- ☐ CRYPTOSPORIDIUM/CYCLOSPORA SMEAR
- ☐ CULTURE: BACTERIAL **R**
  - ☐ AEROBIC & ANAEROBIC W/ GRAM STAIN
  - ☐ ANAEROBIC
  - ☐ BLOOD
  - ☐ ROUTINE (AEROBIC ONLY)
  - ☐ ROUTINE W/ GRAM STAIN
  - ☐ GROUP A BETA STREP (THROAT)
  - ☐ GROUP B BETA STREP (VAGINAL/ RECTAL)
  - ☐ STOOL
  - ☐ **URINE***
- ☐ FUNGUS CULTURE **R**
- ☐ GIARDIA ANTIGEN
- ☐ GONORRHEA PROBE
- ☐ GONORRHEA & CHLAMYDIA PROBES
- ☐ GRAM STAIN
- ☐ HERPES CULTURE
- ☐ HERPES PCR
- ☐ INFLUENZA RAPID ANTIGEN SCREEN
- ☐ KOH PREP
- ☐ MYCOPLASMA/UREAPLASMA CULTURE
- ☐ OVA & PARASITES X _____ (#)
- ☐ RSV
- ☐ VIRAL CULTURE
- ☐ WET PREP

FOR THE FOLLOWING PROFILES SELECT INDIVIDUAL TESTS REQUIRED

VITAMINS

- ☐ VITAMIN A
- ☐ VITAMIN D, 125
- ☐ VITAMIN D, 25
- ☐ VITAMIN E
- ☐ VITAMIN K
- ☐ VITAMIN B12
- ☐ VITAMIN B6

DRUG ABUSE SCREEN (U)

- ☐ AMPHETAMINES
- ☐ BARBITURATES
- ☐ BENZODIAZEPINES
- ☐ COCAINE
- ☐ MARIJUANA
- ☐ OPIATES

HYPERCOAGULATION PROFILE

- ☐ PROTEIN C RESISTANCE
- ☐ PROTEIN C ACTIVITY
- ☐ PROTEIN S ACTIVITY
- ☐ ANTITHROMBIN III ACTIVITY
- ☐ LUPUS ANTICOAGULANT
- ☐ **PT WITH INR***
- ☐ **PTT***

RHEUMATOID PROFILE/IMMUNE SURVEY

- ☐ TOTAL PROTEIN
- ☐ CRP
- ☐ IMMUNOGLOBULINS
- ☐ ANA **R**
- ☐ RHEUMATOID FACTOR
- ☐ COMPLEMENT (C3,C4)
- ☐ ELECTROPHORESIS (SERUM) **R**

HEPATITIS

- ☐ HEPATITIS ACUTE PANEL
- ☐ HEP B SURF AB
- ☐ HEP B SURF AG
- ☐ HEP C AB
- ☐ HEP C AB W/REFLEX
- ☐ HEP C QUANT
- ☐ HEP C GENOTYPE

LAB USE ONLY

L GR GO R BL

UR SW OT

TECH_____

Special Instructions: _____

Lab Copy – White Physician/Agency – Canary

StoreroomForm_320_0797 REV. 1/05

General Request Form (Back)

CHEMISTRY PROFILES

When ordering Chemistry Panels use caution to avoid ordering duplicate testing.

Basic Metabolic Panel (BMP) 80048
Comprehensive Metabolic Panel (CMP) 80053
Electrolyte Panel (Lyte) 80051
Hepatic Function Panel (HFP) 80076
Lipid Group (Cardiac Risk) (Lipid) 80061
Renal Function Panel (RFP) 80069

	RFP	Lyte	BMP	CMP	HFP	Lipid
Albumin	*			*	*	
Alkaline Phos				*	*	
ALT (SGPT)				*	*	
AST (SGOT)				*	*	
Bilirubin, Direct					*	
Bilirubin, Total				*	*	
BUN	*		*	*		
Calcium	*		*	*		
Cardiac Risk Factor						*
Chloride	*	*	*	*		
Cholesterol						*
Creatinine	*		*	*		
CO2	*	*	*	*		
Glucose	*		*	*		
HDL Cholesterol						*
LDL Cholesterol						*
Potassium	*	*	*	*		
Protein, Total				*	*	
Sodium	*	*	*	*		
Triglyceride						*
Phosphorus	*					

HEMATOLOGY

CBC w/PLC 85027
Hematocrit
Hemoglobin
Indices
Platelet Count
RBC (Red Blood Cell Count)
WBC (White Blood Cell Count)

CBC w/PLC and Diff 85025 R
CBC w/PLC
WBC Differential

OTHER

General Health Panel 80050
Comprehensive Metabolic Panel
CBC w/Differential **R**
TSH

Acute Hepatitis Panel 80074
HBsAg
HBcAb, IgG & IgM
HAAb, IgM
HCAb

Prenatal Panel 80055
CBCD **R**
HBsAg
Rubella Ab
RPR
ABO & Rh **R**
Antibody Screen **R**

(R) Reflex Testing Listing

The following tests may reflex to the indicated components when reflex parameters are met. Each additional CPT code will be charged accordingly.

TSH (84443) may reflex to FT4 (84439)
ANA Qualitative (86038) may reflex to ANA Quantitative (86039) and nDNA (86225)
ASO Anti-strep Screen (86063) may reflex to Anti-Strep Titer (86060)
Beta Strep Group A Antigen Screen (86850) may reflex to Beta Strep Group A Culture (87081)
Blood Type and Screen: Antibody Screen (86970), may reflex to some or all of the following: Antibody ID (86970), DAT (86880), Antigen Testing (86903), Antibody Titer (86886), Antibody Elution (86860)
CBCd (85025) may reflex to CBCp (85027) and Diff-manual (85007)
Culture Urine if indicated - may reflex to urine culture (87086)
Cultures may reflex to identification and/or Antibiotic Susceptibilities (87186)
Electrophoresis (84165) may reflex to Immunofixation (86334), Quantitative Immunoglobulins IgG, IgA, IgM (82784x3)
Hepatitis C Antibody (86803) may reflex to Hepatitis C RIBA (86804)
RPR (86592) may reflex to Quantitative RPR (86593)
Lipid (80061) may reflex to direct LDL (83721)
Cholesterol (82465) may reflex to Lipid (80061)

StoreroomForm_320_0797 REV. 3/03

Maine Center for Disease Control and Prevention Influenza Virus Specimen Submission Form 7/09

*This form **must be submitted** with Influenza virus test requests. Specimens that are submitted for Influenza testing without this form may be delayed or not tested. A HETL requisition is **required** for all specimens submitted. Specimens will not be tested without a HETL requisition.*

Patient Information

Last Name: First Name:

DOB: _____/_____/_____ Phone Number: (_____)_____-_____

Gender: Race: Ethnicity:

Address:

Clinical Information

Treating Physician Name: Phone Number:(_____)_____-_____

Date of symptom onset (fever or respiratory symptoms) / /

Rapid test for influenza: ☐ Positive ☐ Negative ☐ Not Done

Pregnant: ☐ Yes ☐ No **Health Care Worker:** ☐ Yes ☐ No

High Risk of severe disease due to underlying medical conditions: ☐ Yes ☐ No

Hospitalized > 24 Hours: ☐Yes ☐No

If Hospitalized:

Name of Hospital:

Clinical Prognosis: ☐ Good ☐Fair ☐ Critical Date of admission: / /

Admitted to ICU: ☐ Yes ☐ No Put on Ventilator: ☐Yes ☐No

Exposure Setting

Is patient associated with any of the following institutions?

☐ Day Care
☐ School
☐ College/University/Boarding School
☐ Camp
☐ LTC/Skilled Nursing
☐ Homeless Shelter
☐ Military
☐ Correctional facility
☐ Other Residential/Group Setting:

Name of institution(s):
Location:

To Be Completed By Maine CDC Staff:

Date Reported State: / / Date Specimen Received at HETL: / /

Tested: ☐ Yes ☐ No If no, why? Epidemiologist:

If not tested: Person notified: Date Notified:

HETL #:

Prenatal Testing Request Form (page. 1)

PRENATAL TESTING REQUISITIONS
(use this page with 1st trimester PAPP-A only)
Remove this page to order other tests

Items listed in red are required for matching samples

FBR FOUNDATION FOR BLOOD RESEARCH www.fbr.org

Mailing Address: P.O. Box 190 Scarborough, ME 04070-0190

Shipping Address: 69 U.S. Route One Scarborough, ME 04074

Tel: (207) 883-4131
ME Only: 1-800-639-8605
FAX: (207) 883-1527

PLEASE HAVE BLOOD DRAWN BETWEEN
_____/_____ AND _____/_____

PATIENT NAME: LAST, FIRST, MIDDLE

ADDRESS (STREET No. or P.O. BOX)

CITY STATE ZIP CODE

DATE OF BIRTH

SEX: M F

REFERRING DOCTOR

SAMPLE DRAW DATE

PATIENT CODE

HOSPITAL CODE

SENDER: (Hospital or Laboratory ID)

FOR FBR USE
18272A

INTEGRATED testing for Down Syndrome requires 2 samples:
a 1st trimester (8-13 weeks)
PAPP-A sample (at NO CHARGE)
a 2nd trimester (15-21 weeks)
AFP Profile Four sample (normal charge)

BOTH samples must be received and matched by the FBR according to the number on this requisition slip in order for the INTEGRATED serum tests results to be reported.

THIS BOX MUST BE CHECKED, IF TESTING REQUESTED

☐ **INTEGRATED SERUM TEST -- First Trimester PAPP-A**

If INTEGRATED testing is REQUESTED, complete this top sheet only and submit it along with the first trimester sample. Please have the patient check the "YES" box and sign the requisition. Retain the remainder of this numbered requisition in the patient's chart for use with the 2nd trimester sample.

GESTATIONAL AGE INFORMATION REQUIRED

First day of LMP: _____ / _____ / _____
If ultrasound done, _____Wks. on date of US _____/_____/_____

If INTEGRATED testing is DECLINED, have the patient check the "NO" box, sign the form, and keep this sheet for your records.

If INTEGRATED testing was NOT OFFERED to this patient, remove and discard this sheet to select other types of prenatal testing.

Consent to take part in the Integrated Serum Test study screening for Down syndrome

•**You are being asked to take part in a study** of a new way to screen for Down syndrome in the developing baby. You can take part in this study if you have a prenatal visit between 8 and 13 weeks. You must also plan to have prenatal screening later in pregnancy. The Integrated serum test uses the results from tests on blood sample collected during both visits.

•**The Integrated serum test will benefit you directly** in this pregnancy because your chance of having a false positive test result will be lowered. A false positive test result means that you would be asked to think about having an ultrasound and/or amniocentesis. The results of this study will also help other pregnant women as well.

•**At an early prenatal visit you will be asked for a small amount of blood.** This will be sent to the laboratory and frozen until the second blood sample is received. Only then will the samples be tested. Your doctor will be given a risk for Down syndrome in your developing baby. Any blood left over will be frozen and stored by code number only. It may be used to develop other new tests.

•**The blood may be drawn at the same time** that you will be having blood drawn for other tests. There are no risks to you except for the usual risks of having blood drawn. These include brief pain as the needle goes into your arm, or that a small amount of bleeding under the skin that might cause a bruise. The risk of more serious problems is very small.

•**You will be asked the same questions** that pregnant woman are usually asked when having blood drawn. Someone may also contact you from this study later in your pregnancy. They will ask you how you felt about helping with this study.

•**If you agree to take part in this study,** you are also letting us ask your doctor or hospital about this pregnancy and the health of your baby.

•**Information about you in the study will be confidential.** Results will be grouped together. No one will be able to identify you.

•**There will be no extra cost to you beyond the usual charge** for routine prenatal screening. This is typically covered by insurance. Your help with this study will take about ten (10) minutes.

•**Your help with the study is voluntary.** Whether or not you participate will not affect your other medical care.

•**Ask your doctor for a copy of the Integrated Serum Test Study pamphlet.** Read it and keep it for your records. If you have any questions about this study, contact Edward M. Kloza, the study coordinator, at the Foundation for Blood Research, 1-800-639-8605.

I have read, or have had read to me, the information above. I have had a chance to discuss it and have my questions answered.

YES ☐ **I agree to participate**

Signed_____ Date_____

NO ☐ **I DO NOT agree to participate**

Vers. 04/01

Prenatal Testing Request Form (page. 2)

MEDICARE/MEDICAID All areas in red must be completed

PRENATAL TESTING REQUISITION

FBR FOUNDATION FOR BLOOD RESEARCH www.fbr.org

Mailing Address: P.O. Box 190 Scarborough, ME 04070-0190

Shipping Address: 69 U.S. Route One Scarborough, ME 04074

Tel: (207) 883-4131
ME Only: 1-800-639-8605
FAX: (207) 883-1527

PLEASE CHECK: ☐ BILL SENDER ☐ BILL PATIENT ☐ BILL INSURANCE

If insurance information or patient address are not provided, charges will be submitted to Sender

PLEASE HAVE BLOOD DRAWN BETWEEN _____/_____ AND _____/_____

PATIENT NAME: LAST, FIRST, MIDDLE

BILLING ADDRESS (STREET No. or P.O. BOX)

CITY STATE ZIP CODE

SENDER: (Hospital or Laboratory ID)

FOR FBR USE 18272A

DATE OF BIRTH SEX: M F

SAMPLE TYPE: SAMPLE DRAW DATE

REFERRING DOCTOR

PATIENT CODE HOSPITAL CODE

FOR PATIENT OR INSURANCE BILLING --- COMPLETE THE INFORMATION BELOW

BILL TO RELATION TO PATIENT

SUBSCRIBER ID/CERTIFICATE NO.

INSURANCE NAME GROUP/EMPLOYER GROUP NO.

INSURANCE ADDRESS: STATE

Information relative to these testing services may be requested from or released to third parties for the purposes of clinical assessment or to process claims for payment of benefits.

(complete all of part A) **CHECK TEST(S) REQUESTED**

- ☐ **INTEGRATED SERUM TEST (1st trimester PAPP-A plus AFP4)**
- ☐ **AFP PROFILE FOUR** (AFP, Estriol, hCG, Inhibin)
- ☐ **AFP PROFILE** (AFP, Estriol, hCG)
- ☐ **AFP ONLY -- not for routine screening** (appropriate only after CVS/amnio or elevated AFP)
- ☐ **COTININE circle serum or urine** (complete smoking section bolded in part A)
- ☐ **AMNIOTIC FLUID AFP** **(complete all of part B)** Includes reflexive ACHE and Blood Contamination studies if indicated
- ☐ **ACETYLCHOLINESTERASE (ACHE)** **(complete all of part B)** Includes amniotic fluid AFP and Blood Contamination Studies
- ☐ **FETAL and MATERNAL BLOOD CONTAMINATION**
- ☐ **BOVINE SERUM (BSA) CONTAMINATION**

☐ Unless this box is checked, any remaining sample and clinical information may be used to develop future laboratory tests.

PART A **Is this test a repeat? Y N**

First day of LMP: ____ / ____ / ____

If ultrasound was done: _____Wks. on date of US _____/_____/_____ Is measurement by BPD? Y N

Height: _____ Current weight (lbs.): _____

Circle Race: Caucasian Black Other

Family history of Spina bifida, Anencephaly, or Hydrocephaly? Y N
If yes, describe:

Pregnancy History: G P Ab Vaginal bleeding with this pregnancy? Y N

Does the patient have insulin dependent diabetes which began prior to this pregnancy? Y N

Has the patient ever been pregnant with a baby diagnosed to have Down syndrome? Y N

Has the patient had an amniocentesis? Y N If yes, date ____ / ____ / ____

Is this a multiple pregnancy? Y N

If yes, number of fetuses _____

Is this an IVF pregnancy? Y N

If yes, age of egg donor: _____

Does the patient smoke cigarettes? Y N If yes, how many cigarettes per day? _____ Is the patient pregnant? Y N

PART B

REASON FOR AMNIOCENTESIS

- ☐ Elevated serum AFP ☐ Abnormal ultrasound ☐ Advanced maternal age
- ☐ History of chromosome disorders ☐ Screen POSITIVE for Down syndrome
- ☐ History of NTD ☐ Other _____

First day of LMP ____/____/____ If ultrasound done: _____ Wks. on ____/____/____

This specimen is: supernatant whole fluid Was it blood stained? Y N

COMMENTS

Vers. 04/01

Tick Submission Form

Acc. #:_____

Date Rec.:_____

Report Sent:_____

Date Ent.:

TICK SUBMISSION FORM
Maine Medical Center Research Institute
Center for Vector-borne Disease
75 John Roberts Road – Suite 9B
South Portland, ME 04106
www.mmcri.org/lyme/
ticklab@mmc.org

As part of a program to monitor the distribution of the deer tick, *Ixodes scapularis,* the vector for the Lyme disease bacteria and other human pathogens, our research laboratory offers free identification of ticks. Ticks will **not be tested** to see if they contain the Lyme disease spirochete because the clinical value of this information is uncertain. Unless other arrangements have been made, ticks should be preserved in small bottles of 70% alcohol and mailed in a crush-proof container with this completed form to the above address. Please be sure to note the town where the tick was acquired and date tick found.

In the late spring and summer, many areas are infested with dog ticks, *Dermacentor variabilis.* This tick does not transmit Lyme disease. Because our laboratory can become overwhelmed by submissions of this tick, we ask that you not submit ticks on which you can distinguish the characteristic faint white markings unique to the dog tick.

To remove ticks, grasp them with fine forceps as near to the skin as possible and pull directly out firmly and steadily. The barbed mouth parts may not let go easily, so a minute or more may be required. Do not handle ticks with your bare hands.

Because we are interested in tick distribution, we may attempt to contact the person who originally collected the tick. If the tick is submitted by a clinic or other organization, please include the original collector's name and address. Please include name of guardian if under 18 years of age.

A. Individual, physician, clinic, or organization submitting tick:

Name: _____

Address: _____

_____ Zip:_____

Phone: _____

E-mail: _____

B. Person (or owner's name if pet) acquiring tick:

Name:_____

Address:_____

_____ Zip:_____

Phone: _____

E-mail: _____

Date tick found: ___/___/___ Town where acquired: _____ State: _____

Was the tick attached when found? ☐ Yes ☐ No Body part attached to: _____

Tick found on: ☐ Person (Age of person:_____) ☐ Animal ☐ Other: _____

If found on animal, what species? ☐ Dog (Breed: _____) ☐ Cat ☐ Other: _____

Animal's name: _____ Has animal been vaccinated for Lyme disease? ☐ Yes ☐ No

Were there any associated symptoms? _____

Patients or Physicians, please note any other pertinent information here:

Lab use only:

Tick Identification:

Your resource for life.
MaineGeneral
Medical Center

TRANSFUSION REACTION INVESTIGATION

Signs and Symptoms of Transfusion Reaction

Acute Transfusion Reactions may occur singularly or in any combination:

Chills, Fever, Nausea, Vomiting

Back Pain, Headache, Chest Pressure, Hypotension, Shock

"Burning Sensation" along vein used for transfusion, Itching, Rash

Dyspnea, Oozing from wound or veinpuncture

I. INSTRUCTIONS TO NURSING STATION:

If you suspect a possible Transfusion Reaction:

A. Stop the transfusion immediately. Leave the vein open with I.V. Saline at a slow drip.

B. Call a physician immediately to evaluate the reaction. The physician will make the judgement whether it is a possible Transfusion Reaction, and whether or not the transfusion may continue.

C. Call the Blood Bank immediately and verbally report the possible reaction. The Blood Bank will start an investigation immediately.

D. Obtain pre- and post-transfusion temperature, pulse, and blood pressure.

E. Return to the Blood Bank:
   1. A Transfusion Investigation Form with completed clinical data.
   2. The transfusion bag with the attached administration set (even if they appear empty).
   3. Post-Transfusion urine sample.

II. INSTRUCTIONS TO PHYSICIAN:

A. Continue with transfusion of the same unit only when there is a urticarial reaction which responds to oral or I.M. antihistiamines. For other types of reactions do not continue transfusion of the same unit.

B. Results of immediate transfusion investigation procedure will be telephoned to you or the nursing station.

C. Institute therapy as indicated. If there is evidence of hemolysis, DO NOT DELAY. Immediate therapy may be lifesaving.

D. Consult the Pathologist regarding transfusion investigation workup and further transfusions.

DISCARD THIS SHEET WHEN NO LONGER NEEDED

Transfusion Reaction Report Form

Your resource for life.
MaineGeneral Medical Center

TRANSFUSION REACTION INVESTIGATION

TRANSFUSION
Began Date: _____ Time _____ Component _____
Ended Date: _____ Time _____ Amt. Giv. _____ ml

SYMPTOMS
Began Date: _____ Time _____

☐ Hives
☐ Chills
☐ Vomiting
☐ Pain
☐ Other _____
☐ Itching
☐ Fever
☐ Hematuria
☐ Rash
☐ Nausea

	Before	After
Temp.		
Pulse		
B.P.		

COMMENTS:

Patient Identification

Physician Initiating Investigtion:

BELOW FOR BLOOD BANK USE ONLY

Donor No.	Unit Expires	Patient Identification and Labels: _____ Correct _____ Incorrect Donor Identification and Labels: _____ Correct _____ Incorrect

COLOR OF SERUM	
Pre	
Post	

	DAHG
Pretransfusion	
Posttransfusion	
* Donor Segment	

* If indicated

POST URINE ROUTINE
COL/APP
SP GR
pH
CHEM (Blood)
MICRO:

	CELL TESTING					SERUM TESTING			CELL I			CELL II			
	A	B	Rh Cont	D	Du	A_1	B	Interpretation	S	A 37P	AGH	S	A 37P	AGH	Interpretation
Pretransfusion															
Posttransfusion															
Donor Segment															

CROSSMATCH	MAJOR S	A 37P	AHG	Interpretation
Pretransfusion				
Posttransfusion				

Bacteriological Studies	Gram Stain	Culture
Donor Bag/Seg.		

Pathologist notified of Positive Gram Stain

By _____ Date _____ Time _____ Initials of Tech _____

	EDTA SAMPLE				SERUM SAMPLE		
	Color	Hct	RETIC	Misc.	Bili.	Creat	Misc.
Pretransfusion							
Posttransfusion							

*NI = NOT INDICATED

COMMENT / INTERPRETATION

1. Pathologist Notification of Reaction
   By_____ Date_____ Time_____
2. Positive Gram Stain Notification
   By_____ Date_____ Time_____

Technologist_____Date_____ Pathologist_____ Date_____

White – Chart Copy Yellow – Laboratory Copy