

Lab Use Only	
Donor MRN	_____
Donor FIN	_____

REQUISITION FOR TRANSPLANT DONOR TESTING

For St. Louis Children's Hospital Clinical Laboratories

Please fill out this form in detail. Providing all the information requested.

Recipient name: _____

Recipient MRN: _____

Donor UNOS#: _____

Date: _____ Time: _____

Tests requested:

- | | |
|---|--|
| <input type="checkbox"/> Epstein Barr Virus IgG | <input type="checkbox"/> Routine Culture (C RA) Donor Bronchus |
| <input type="checkbox"/> HLA Monitoring | <input type="checkbox"/> Routine Culture (C RA) Donor Solution |
| <input type="checkbox"/> Save Serum | <input type="checkbox"/> Viral Respiratory Culture (C VRST) Donor Bronchus |
| <input type="checkbox"/> Toxoplasma IgG | |

Additional tests: _____

Lab use only

1. Register in SMS using the mini reg application as described below.
2. The last name on this registration should be "Donor".
 The first name is the recipient's last name followed by recipient's first name without any spaces." (ie..Donor, Doejohn)
3. For the date of birth use the current date. (today)
4. For the patient's sex always use Male.
5. For race use Unknown.
6. In the POS field use TRAN for the transplant clinic
7. Write the MRN and FIN of this registration on the top right corner of this form
8. File one copy in SMS req file for registration staff to complete registration.
 Give one copy to department performing the testing
 File one copy in folder for customer service review.
9. Transplant coordinator will contact Customer Service for a copy of this form.

Registration use only

1. Registration will complete the update
2. To discharge account use V42.6.
3. Insurance should be set-up as E01, and Subscriber should be the patient.
4. Guarantor should be recipient.
5. Guarantor's address should be the recipient's medical record number
6. DOB should be the current date of service
7. Discharge Disposition should be expired - XBZ

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