Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Patient Screening - Lab Requisition

Department of Laboratories
4800 Sand Point Way N.E., OC.10.858
Seattle, WA 98105 (206) 987-2102
www.seattlechildrens.org/labman

Patient's Last Name,	First	Middle	Birth date:	Sex:
Patient Address:			Patient Phone Number:	
Seattle Children's MRN:	**DRAW FEE/ TESTING/ HANDLING FEES TO BE BILLED TO:**			
Ordering Provider: **Dr. Danielle Zerr**	**INFECTION CONTROL - SEATTLE CHILDREN'S HOSPITAL** **4800 SAND POINT WAY NE, MAILSTOP: RA.3.329** **SEATTLE, WA 98105**			

PLEASE FAX RESULTS TO SEATTLE CHILDREN'S INFECTIOUS DISEASE DEPT @ FAX#: (206) 987-3890

SPECIMEN INFORMATION: Date collected: ____ / ____ / ____

Time collected: ________ am / pm ☐ Whole Blood ☐ Serum ☐ Plasma

ICD10 Code: Z01.89

REQUIRED TESTING

SPECIMEN REQUIREMENTS ***(if sending to SCH Lab)***

	Test	Normal Volume	Minimum Volume
☒	**Hepatitis B Surface Antigen**	2 mL in a gold / SST tube	1 mL
☒	**Hepatitis C Antibody**	2 mL in a gold /SST tube	0.5 mL
☒	**HIV Antigen & Antibody**	3 mL in a lavendar / EDTA tube	3 mL
☒	**Hepatitis C Quant. by PCR**	4 mL in a lavendar / EDTA tube	2 ml

OTHER

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CHECK WITH THE PERFORMING LABORATORY FOR SPECIMEN REQUIREMENTS & SPECIAL PROCESSING INSTRUCTIONS

* FOR BILLING OR COLLECTION QUESTIONS, CONTACT SEATTLE CHILDREN'S LABORATORY CLIENT SERVICES DEPARTMENT @ (206) 987-2617 *