HEMOSURE iFOB OCCULT BLOOD TESTING FORM

Patient Name:_________________________________________________

MRN:________________________________________________________

Ordering Provider:_____________________________________________

Collection tube one:   Date:__________  Time:_________  Results: __________  QC: _________

Collection tube two:   Date:__________  Time:_________  Results: __________  QC: _________

Collection tube Lot # ______________________   Exp Date:____________________________

Cassette Lot # ______________________   Exp Date: ___________________________

Date tested: ________________________

Test performed by: ______________________________

**Original**: to go to Hematology for testing and held in Hematology until order completed. After results are entered, form goes to CLP and is filed with the requisition.

**Copy**: to be held in CLP until order is received. Once the order is received, the CLP copy will be shredded.