Mass Spectrometry Immunosuppressant Testing, Dried Blood Spot

Division of Pathology • 513-636-4203

PATIENT DEMOGRAPHICS

Patient Name: _____ , _____ , ___
Last First MI

Date of Birth (MM/DD/YYYY): _____ / _____ / _____

☐ Male ☐ Female

SAMPLE/SPECIMEN INFORMATION

Specimen Type: _____

Collection Date (MM/DD/YYYY): _____ / _____ / _____

Collection Time: _____

Note: Please see test information sheet for acceptable specimen type, collection container, and volume.

SHIPPING INFORMATION

Ship to:

Clinical Mass Spectrometry Facility, MLC 7019
Department of Pathology and Laboratory Medicine
Cincinnati Children's Hospital Medical Center
240 Albert Sabin Way
Cincinnati, OH 45229-3039

TEST(S) REQUESTED

Therapeutic Drugs:

☐ EVEROLIMUS LEVEL, DRIED BLOOD SPOT

☐ SIROLIMUS LEVEL, DRIED BLOOD SPOT

☐ TACROLIMUS LEVEL, DRIED BLOOD SPOT

ORDERING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (_____) _____

Secure Fax: (_____) _____

_____ Date: ____/ _____/ _____
Referring Physician Signature (REQUIRED)

Comments: _____

BILLING INFORMATION

Physician Name (print): _____

Diagnosis Code(s): _____

Billing and Report Mailing Address: _____

_____

_____

_____

This laboratory DOES NOT directly bill patients or insurance companies for non-CCHMC patients

CPT Code: 80197
CCHMC Tax ID: 31-0933936
CLIA: 36D0656333

EXAMPLE

INSTRUCTIONS: Draw 30 minutes to 1 hour before next dose. Note date and time of collection on requisition. Collect 3 full circles on dried blood spot collection card (see below), allow to air dry for 3 hours, and submit (or mail) to Cincinnati Children's Hospital Mass Spectrometry Laboratory.

EXAMPLE ONLY. DO NOT USE.