CHILTON HOSPITAL

97 West Parkway, Pompton Plains, NJ 07444
973-831-5000 www.chiltonhealth.org

PATIENT LABEL

REQUEST FOR SURGICAL PATHOLOGY AND NON-GYN CYTOPATHOLOGY

DATE OF SERVICE:_______________________ **062** LAB SPEC # **-SP-**_______________________

SPECIMENS	Please indicate procedure requested. *Provide separate slips for Microbiology and Special Studies	Frozen	Histology	Cytology	*Micro-biology	*Spec. Study	RN Initials
1.		☐	☐	☐	☐	☐	☐
2.		☐	☐	☐	☐	☐	☐
3.		☐	☐	☐	☐	☐	☐
4.		☐	☐	☐	☐	☐	☐
5.		☐	☐	☐	☐	☐	☐
6.		☐	☐	☐	☐	☐	☐

Procedure/Operation:

Clinical History/Pre-op Diagnosis:

Post-op Diagnosis:

Special Instructions:

ICD-9 Code(s):

MD Signature:	Date:
VOVR:	Date:
Copies To:	

For lab use only: CPT CODES (Indicate Quantity)

______ 88300	______ 88329	______ 88312	______ 88112
______ 88302	______ 88331	______ 88313	______ 88161
______ 88304	______ 88332	______ 88342	______ 88305 (cell block)
______ 88305	______ 88333	______ 88311	
______ 88307	______ 88334		
______ 88309			

Pathologist ICD-9: ______

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NAME, ADDRESS, DATE

DEPARTMENT OF PATHOLOGY
INTRAOPERATIVE CONSULTATION

THIS SECTION TO BE COMPLETED BY SURGEON OR BY NURSE UNDER SURGEON'S DIRECTION

Date: ______________________ Surgeon: ______________________

Time of Request: ______________________ OR # ____________ Extension # ____________

Time Received in Pathology: ______________________ Patient: ☐ Awake ☐ Asleep

CLINICAL DATA

Exact site of tissue: ______________________

Clinical Impression: ______________________

History (including any prior tumor): ______________________

____

____

THIS SECTION TO BE COMPLETED BY PATHOLOGIST

CONSULTATION REPORT

Case No.: -SP-______________________ Tech. Init.: ______________________

☐ Gross Examination ☐ Frozen Section ☐ Cytology ☐ OR Consult

Specimen(s) Received ______________________

____

Diagnosis ______________________

____

____

Date: ______________________ Reporting Pathologist: ______________________

Time Reported: ______________________ Reviewing Pathologist: ______________________

How reported: ☐ Intercom ☐ Telephone ☐ Other ______________________

Sections prepared by: ☐ Technologist ☐ Pathologist

White: Chart Yellow: Statistics Pink: Pathology

CMH Graphic Arts
110-007 R0804

BLOOD BANK ORDER FORM

PATIENT LABEL

• **TELEPHONE / VERBAL ORDERS MUST BE SIGNED WITHIN 48 HOURS.**

Transcriber's Initials	**TELEPHONE ORDER VERIFIED BY REPETITION = TOVR** **VERBAL ORDER VERIFIED BY REPETITION = VOVR**	RN's Initials
	Consent for Transfusion Obtained: ☐ Yes ☐ No, pending	
	☐ **Type and Screen (T&S)** ☐ **Type and Rh (T&Rh)**	
	Has the Patient been transfused in the last three months? ☐ Yes ☐ No Has the Patient been pregnant in the last three months? ☐ Yes ☐ No	
	Red Cell Order: / **Indication:** ☐ **RBC's** – Packed Red Cells (quantity ________) / ☐ Hgb less than 8.0 ☐ Acute Bleeding ■ **Type & Screen** if not done in the last 72 hours. / ☐ Surgery ☐ ____________	
	Product Order: / **Indication:** ■ **Type & Rh** if Type & Rh or Type & Screen was not done during this hospital stay. ☐ **Fresh Frozen Plasma** (quantity ________) / ☐ PT is 1.5 times high normal ■ 10-20 ml / Kg body weight / ☐ Reverse anticoagulant therapy ■ 1 unit = approximately 250ml / ☐ Other: ☐ **Platelets** (quantity ________) / ☐ Prophylactic – Platelet Count less than 15,000 ■ Apheresis 1 unit / 70 kg body weight / ☐ Febrile – Platelet Count less than 20,000 ☐ Bleeding – Platelet Count less than 50,000 ☐ Going to Surgery – Platelet Count less than 100,000 ☐ Thrombocytopathy ☐ **Cryoprecipitate** (quantity ________) / Patient is deficient of: ☐ Fibrinogen ☐ Factor V ■ 1 unit / 7 Kg body weight / ☐ Factor XIII ☐ Other ____________	
	Other: / **Indication:** ☐ **Irradiated products** (quantity ________) / ☐ Immunocompromised ☐ Neonate ☐ Bone marrow transplant ☐ **HLA Matched** (dose ________) / ☐ Patient has HLA antibodies ☐ **CMV Negative Products** (quantity ________) / ☐ Immunocompromised and CMV negative ☐ **Other:** ____________ / ☐ **Indication:** ____________	
	Transfusion Orders:	

TOVR / VOVR / Chart Order (Circle) Received from Dr.: ____________ Taken by: ____________ RN	Date:	Time:
Practitioner's Signature:	Date:	Time:
Practitioner's Name (Printed): #	**FAXED**	
RN's Signature:	Date:	Time:
I have taken a blood specimen from patient named above, verified patient identification and labeled sample at bedside from armband. Signature: ____________	Date: Time:	Blood Bank Yellow Sticker **ALL 3 PAGES**

CHILTON
HOSPITAL

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Hematology Dept.

Instructions for Semen Analysis Collection

1. **Schedule an appointment** for Semen Analysis prior to collection- Monday through Friday, between 7 am and 11 am only. No Holidays or Weekends. Call the laboratory at 973-831-5204 for an appointment.

2. Follow your doctors' instructions for the collection of a semen sample. Patient must abstain from ejaculation for at least 2 days before and including the day of collection of the specimen.

3. Do not use any type of lubricant, as it interferes with the procedure, and can give false results.

4. Semen specimen should be collected in a sterile, screw top (leak proof) specimen container. Take care to collect the entire sample in the container.

5. Semen specimen must be kept at **body temperature** at all times.

6. Bring all necessary insurance information with you for proper registration, and upon arrival at the hospital, state that the specimen must be delivered to the lab ***immediately!***

7. Semen specimen must be delivered to the lab ***immediately***, as **testing must begin within 1 (ONE) hour after *collection.*** A collection form must be filled out at the lab, before you leave.

8. **Label container** with the following information:
   - Name
   - Date and Time of collection
   - Testing for Fertility or Post Vasectomy

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Hematology Dept.

Semen Analysis Collection Information

To be completed by patient upon registration
>>

Name:________________________________

Doctor:_______________________________

Test Ordered:
1. ____ Semen Analysis
2. ____ Post-Vasectomy

Date of Collection:____________________

Time of Collection:____________________

Time of Receipt :_____________________

Method of Collection: Masturbation________
Coitus ____________
Other______________

Type of Specimen Container: Sterile Specimen Container: ____________
Other: __________________

Days of Abstinence: _________________

Was the entire sample collected in the container? ____________________

Was the specimen kept at body temperature?_________________________

>>