Cellular Therapy Laboratory

1036 Fuller Ave NE Grand Rapids, MI 49503
Phone (616) 233-8698 Fax (616) 233-8559

INFECTIOUS DISEASE MARKER (IDM) TESTING REQUEST

Fill out this form **COMPLETELY** and send with samples. See below for sample handling.

Affix hospital label or complete:

Name: ________________________________

DOB: _________________________________

MRN: _________________________________

☐ Autologous Patient

☐ Allogeneic Recipient

☐ Allogeneic Donor

Recipient Name: _______________________

IDM Testing Request: ☐ Standard Panel **(No CMV)** ☐ Enhanced Panel **(Includes CMV)**

HEMODILUTION ASSESSMENT:

☐ Individual is 12 years old or younger:

Has the patient received any colloidal agent (including blood products) in the 48 hours prior to IDM sample procurement?

☐ Yes

☐ No

Has the patient received any crystalloid agent in the one hour prior to IDM sample procurement?

☐ Yes

☐ No

☐ Individual is older than 12 years:

Has the patient received more than 2 liters of any colloidal agent (including blood products) in the 48 hours prior to IDM sample procurement?

☐ Yes

☐ No

Has the patient received more than 2 liters of any crystalloid agent in the one hour prior to IDM sample procurement?

☐ Yes

☐ No

Hemodilution Assessment Performed By: ___________________________ Date: ________________

Sample Collected By: ___________________________ Date: ________________ Time: _____________

Sample Requirements – Peripheral Blood (Tubes must be full to complete all required testing)

Adult	**Pediatrics**
1 – 6ml plain clot tube (no anticoagulant, no gel)	1 – 6ml plain clot tube (no anticoagulant, no gel)
2 – 6ml EDTA tubes	1 – 6ml EDTA tubes

Send samples to Versiti Michigan at refrigerated temperature (2-8°C) with completed form

Versiti Michigan Use Only:

Date/Time Received: _____________________ Second Check of Final Results: _____________________

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