HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

AUTOMATION LABORATORY
7 Founders Building
662-6833

HUP BLOOD GAS REQUISITION
CODE CALL / RRT ONLY

ALL AREAS MUST BE COMPLETED
Affix patient's sticker or complete all information

NAME:

MR#:

DOB:

GENDER:

DATE: TIME:

Requesting Physician's Name (print)	**MANDATORY:** Phone number to receive results:
Location:	Lab call results to above number

Source: circle Arterial Venous

Minimum volume: 1 mL

X	Full Panel Includes: pH, pO_2,CO_2, H/H, O_2 Saturation, ionized Ca^{++}, COOX, HCO_3, Na, K, Cl, Lactate, Creatinine, Glucose

(lab use only - SABG-arterial; SVBG - venous)

SPECIMEN LABEL REQUIREMENTS
PREPRINTED OR HANDWRITTEN LABEL MUST HAVE
PATIENT NAME & MR#
SPECIMENS WILL BE REJECTED IF LABEL LACKS
PATIENT NAME & MR#

REMOVE NEEDLE FROM SYRINGE BEFORE SENDING TO THE LAB

BB-017-3 5/2023