HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA-Cedar Ave.
DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

1st Floor Laboratory
215-748-9181

HUP Cedar BLOOD GAS REQUISITION

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, Glucose

(lab use only - ABL 90 ART-arterial; ABL 90 VEN - venous)

SPECIMEN LABEL REQUIREMENTS:
Must be labeled with a Patient Chart Label
SPECIMENS WILL BE REJECTED IF NO LABEL ON SPECIMEN

REMOVE NEEDLE FROM SYRINGE BEFORE SENDING TO THE LAB