Avera Laboratory Network – Aberdeen Service Center
Avera St. Luke's Hospital Laboratory
305 South State Street
Aberdeen, SD 57401

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Mission Statement and Services

Mission Statement:

Our locally owned and operated *Avera LabNet* Service Center located in Aberdeen offers a comprehensive laboratory outreach service to physicians, hospitals, clinics, nursing homes and other providers requiring laboratory services in our five state region.

Our Service Center is equipped with state-of-the-art methodologies and equipment to provide testing in all major clinical specialties. Test offerings are further enhanced through direct, quality relationships with nationally recognized laboratories specializing in esoteric laboratory testing.

Integrated, personalized, and caring services are the outstanding features of our *Avera Laboratory Network*. We acknowledge the importance of providing integrated services in our five state region but our services continue to emphasize our belief that each of our customers and the patients they serve, have needs that are unique and require individually structured services. Therefore, we strive at all times to personally customize our services to meet the needs of the customers we serve.

Professional Staff:

Avera St. Luke's Hospital Laboratory is quality driven by board certified pathologists. Our pathologists serve as active clinical consultants and are available 24 hours a day for consultation on concerns related to appropriate test utilization, test result interpretive assistance or any concerns that may occur in the course of patient management.

In addition, our laboratory takes pride in our dedicated clinical laboratory professionals which include directors, managers, consultants, technical staff and customer support staff whose combined education, experience and expertise assure quality through all pre-analytical, analytical, and post-analytical phases of laboratory and customer support services.

Client Services:

Avera LabNet's Service Center Client Service Representatives take pride in serving our customers needs in a caring and effective manner.

Our Client Service Departments specialize in handling all client needs relating to:

- Specimen requirements
- Test result inquiries
- Test availability assistance
- Client communication needs
- Specialized reporting requirements
- Courier and supply assistance
- Testing change assistance
- Billing inquiries

We take pride in our Client Service Coverage which is available M-F 8 AM to 6 PM to handle all our customers immediate assistance requests relating to direct testing information, specimen requirements and result inquiries. After hours coverage is provided by technical staff on duty.

Logistics:
Avera LabNet Service Center-Aberdeen provides regional courier services at no charge to our service areas in North Dakota and South Dakota. Postal service and specialized contracted courier service may be utilized in areas outside of our direct service region.

Supplies:
Supplies required to assure proper specimen collection, preparation, ordering and transportation to Avera Laboratory Network (ALN) Service Centers are supplied at no charge. Supplies are provided only for those tests referred to ALN.

Supplies may be obtained by telephoning or completing a supply requisition form. Form are available by calling Client Services.

Supplies that may be ordered at no charge include, but are limited to:
- Specimen transport bags, containers and pour-over tubes
- Specialty collection kits and tubes
- Vacutainer tubes for testing being sent to ALN
- Centrifuges for sites that do not operate a CLIA licensed laboratory
- Requisitions and information forms
- Computer hardware/printers as needed to utilize secure online test requisitioning and result reporting if criteria is met

Consultation Services:
Experienced technical advisors are available for administrative and/or technical consultative services. Services offered are structured to meet the individual client's needs at the frequency defined by the individual client and may include, but may not be limited to:
- Review and recommendation on laboratory policies/procedures
- Review and recommendation on quality processes and process improvement strategies
- Performance of instrument validations and/or review of preventive maintenance programs
- Continuing education
- Review and recommendation on regulatory guidelines and accreditation standards

- Assistance in general laboratory management accountabilities in the areas of purchasing, capital equipment, and personnel

Consultation services are charged for on an hourly fee for service basis and require a signed agreement outlining client-requested services and frequency guidelines.

Policy Information Billing and Compliance:

Billing Overview:
Avera LabNet Service Centers are established to perform various types of billing services. It is the responsibility of requesting facility to designate the appropriate type of billing required for the services rendered and to provide correct and complete billing information based on the type of billing to be performed. In the event, that the method of billing is not marked on the requisition or if incomplete billing information is provided, the client may be billed for the services requested.

Client Billing:
Itemized monthly statements will be issued. Terms of payment are net 30 days. If an invoice is in question, please contact your Service Center's Client Service Department who may direct you to our appropriate Business Office personnel for assistance.

Clinic/Physician: *Avera LabNet* Service Centers are required to bill all tests performed on-site on Medicare and Medicaid patients. All other patient types may at the direction of the client be billed to their account.

Hospitals: Hospital clients are required to request Client Billing for all of their Medicare inpatient and outpatient laboratory services.

Medicare/Medicaid Billing:
Avera LabNet Service Centers will bill Medicare and Medicaid programs directly in accordance with all appropriate regulations. It is the responsibility of the submitting client to determine appropriate primary and secondary coverage specifics as required by federal law. All required test requisition information must be supplied at the time the test request is received. Required information includes but may not be limited to:

- Patient's specific demographic information (full legal name, sex, DOB)
- Patient's complete address
- Medicare (or Medicaid) number(s)
- Diagnosis information (ICD-10 Codes)
- Requesting physician's complete name (or last name, first initial)
- Physician NPI number if not previously on file at providing laboratory

In the event that incomplete information is given at the time of the test request, test processing, resulting and reporting may be held until the client has been contacted for the complete information required by federally funded programs.

Patient Billing:
Avera LabNet Service Centers will bill a clinic's or physician's patient directly if complete billing information is provided on the test requisition at the time the specimen is submitted. If you request that we bill the patient directly, please advise the patient to expect a bill from our laboratory. Required information includes:

- Patient's specific demographic information (full legal name, sex, DOB)
- Patient's complete address
- Patient's current phone number, including area code
- Guarantor's complete information (full name, address, phone number, relationship to patient)
- Requesting physician's complete name (or last name, first initial)

Third Party Billing:
Avera LabNet Service Centers will bill third party payers directly upon request. Complete billing information must be provided on the test requisition at the time that the specimen is submitted. Required information includes:

- Patient specific demographic information (full legal name, sex, DOB)
- Patient's complete address
- Policy holder's/Guarantor's complete information (full name, address, phone number, relationship to patient)
- Insurance company complete information (name, address, policy and group number)
- Diagnosis information (ICD-9 Codes)

Compliance and Medical Necessity:
Avera LabNet Service Centers have adopted and implemented comprehensive Compliance Programs that enforce internal controls that promote adherence to applicable federal and state law and the program requirements of federal, state and private health plans. Through these formal programs, we are showing our commitment to the compliance process. We also remind all clients that they too are responsible by law to enforce and abide by rules and regulations relating to compliance regulations.

Medical Necessity and Diagnosis Codes:

- The Medicare program will only pay for tests that meet Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient.
- Organ or disease related panels would only be paid in whole when all components are medically necessary.
- Medicare generally does not cover routine screening tests unless covered under approved screening program criteria.
- It is the responsibility of the laboratory and the ordering physician or other authorized individual to ensure that claims being submitted for payment to federally funded programs occur only when services are covered, reasonable and necessary. Non-covered services must be identified as non-covered services through appropriate mechanisms.
- It is the responsibility of the treating physician, authorized person on the physician's staff or other authorized individual to order tests by law, to maintain in the patient record all required

documentation to support the medical necessity of the service the laboratory has provided and billed to a federal or private health care program.

- It is the responsibility of the treating physician, authorized person on the physician's staff or other authorized individual to order tests by law, to provide at the time of the test request, all specific diagnostic information documenting the medical necessity of the tests requested. ICD-9 coding is the preferred format of providing diagnosis information. In the event that written diagnosis information is given, it must be in such format as to allow for direct conversion to an approved ICD-9 code. Inappropriate diagnostic information includes the use of abbreviations or truncated terminology. In the event, that written diagnosis information cannot be coded, the appropriate individual will be contacted for diagnosis clarification.

Use of Advanced Beneficiary Notices or Waiver of Liability:
An ABN need only be obtained for laboratory testing that Medicare may deny as "not reasonable and necessary" upon submission of the claim. This includes testing for which Medicare has a National Coverage Determination (NCD) or a Local Coverage Determination (LCD) from our Medicare Administrative Carrier (MAC) that defines when the testing is determined by policy to be medically necessary.

When testing ordered is to be referred to a laboratory provider that will not see the patient or have the opportunity to obtain the ABN, the responsibility of obtaining the ABN form in correct format is the responsibility of the referring entity. The completed ABN form must be submitted at the same time that the test is requested and the specimen is sent into the laboratory for testing.

Criteria for an appropriately obtained and documented ABN includes:

- The ABN must be in writing, using approved notice language.
- The laboratory providing services must retain a copy of the ABN. Blanket waivers are not acceptable.
- The ABN must be signed and dated by the beneficiary (or a person acting on the beneficiary's behalf) prior to the service being provided.
- The ABN must cite the specific service (testing) for which payment is likely to be denied.
- The ABN must cite the physician's specific reason(s) for believing Medicare payment will be denied. (The notice is not an acceptable waiver if it is no more than a statement to the effect that there is a possibility that Medicare may not pay for the service.)

Panel Utilization:

- Physician's and other authorized individuals are encouraged, whenever possible, to order individual tests specific to their patient's clinical needs. Panel ordering is not encouraged.
- Only AMA approved organ and disease specific panels will be offered.
- Physicians and authorized individuals are reminded that the Office of the Inspector General (OIG) takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under federal law.

Screening Tests:
An ABN should be obtained for payable screening tests if the service may be denied due to frequency limitations.

Routine screening services are services not covered by Medicare and do not require an ABN.

Non-covered Services:
An ABN is not needed for non-covered services under Medicare due to "statutory exclusion". As a courtesy, please inform your patient that the services are not covered by Medicare. The following service does not require an ABN as it is specifically excluded from the limitation of liability provision: Routine physician checkups (including lab tests furnished as part of the routine physical examination).

CPT Coding:
CPT coding references published by *Avera LabNet* are provided only as guidance to assist you in billing. The CPT codes listed reflect our interpretation of CPT coding requirements only and are subject to change any time. *Avera LabNet* assumes no responsibility for billing errors due to reliance on the CPT codes we publish. It is your responsibility to verify the accuracy of the codes provided and to assign values to each code based on the guidelines for your facility.

For further reference on CPT coding, please consult the CPT Coding Manual published by the American Medical Association, and if you have any questions regarding the use of the code, please contact your local Medicare carrier.

Policy Information
Patient Testing:

Test requesting (overview):

Test requests may only be made by authorized individuals and may only be in written or electronic format. Test requisitions preprinted with customer identification information will be provided at no charge to expedite written test requests.

Each specimen referred to our Service Center must be accompanied by a completed test requisition form (written or electronically generated) that contains all required patient demographic, billing information, compliance information, and test order information. It is the responsibility of the requesting provider to complete all required information. In the event that incomplete required information is supplied, specimen testing and reporting may be held until the customer has been contacted for the information.

For ancillary departments of Avera St. Luke's Hospital, refer to the Order Entry Module to complete this task.

Telephone or verbal test requests will be accepted but do require that written authorization protocol be followed.

Obtaining Orders:

Verbal Phone Orders "Read Back" Policy:

When orders are given over the phone, the orders will be asked to be repeated back to the person from the laboratory, which will include patient's name and orders. This "read back" will be documented in the comments area with the full name of the person reading the orders and the full name of the person receiving the order.

Lab Orders that Need Clarification:
Every attempt will be made to accurately place a written or verbal order in Meditech. If clarification or further interpretation is needed, the unit, doctor or submitting client will be contacted for the information needed. The name of the person contacted to clarify the order will be documented in Meditech.

Inpatients
- Inpatients assigned to a bed location will have orders placed by the attending physician or their designee through Physician Order Management POM). These orders create computer-generated labels, which the laboratory staff takes with them to draw the specimen.

Outpatients:
- Outpatients with a hospital location (ex. ED, SDS, etc.), will have written orders placed by the attending physician through Physician Order Management (POM) These orders create computer-generated labels, which the laboratory staff takes with them to draw the specimen.
- Outpatients that come to the laboratory to be drawn will either come with a written order from their physician, a faxed order before the patient arrives at the laboratory, phoned orders to the laboratory by the physician or their designee, or electronic orders placed via MTA by participating AMG physicians. Any verbal orders will be verified by "read-back" of the results by the person receiving the orders. (See "Read Back" policy above) The laboratory will forward all written or verbal orders to Health Information Management who will notify physicians for signature.

Outreach:
- Outreach orders will be made available to the laboratory on a requisition that has been provided to the outreach client by the laboratory; electronically placed via MTA by participating physicians/clinics; or electronically placed via Atlas by participating clients; or Meditech LIS site batch by participating client The specimen will be matched to the order when received in the laboratory.
- If an outreach client requires a test to be added on to a specimen that is already at the laboratory, an "Add Test" request form is required to be completed by the outreach client, signed and faxed to the laboratory.

Test Add-ons:
The Client Service Departments can arrange to do additional testing on specimens previously submitted for testing providing the following conditions apply:
- Sufficient volume is available
- Original specimen type is acceptable for additional testing requested
- Specimen stability guidelines have not been exceeded

- Additional testing requested does not require documentation that is not available and is required by federally funded programs (i.e. covered by National Coverage Determination or Local Medical Review Policy)
- "Add Test" form has been received. (see appendix)

Result Reporting:

Verbal Phone Results "Read Back" Policy:
When results are given over the phone verbally, the results will be asked to be repeated back to the person from the laboratory, which will include patient's name and the results. This "read back" will be documented in the comments area with the full name of the person receiving the result and the full name of the person reading the results

Inpatients:
- Inpatients assigned to a location will have results available in the EMR as soon as they are verified. Critical results are called to the nursing station for the bed location and the nurse will follow-up with the physician who ordered the test.

Outpatients:
- Outpatients with a hospital location (ex. ED, SDS, etc.), will have the results available in the EMR upon verification of the test result.
- Outpatients that have been discharge in the Meditech system will have the result available in EMR and faxed to the attending physician's fax

Outreach:
- Outreach testing will have results printed/faxed to the client's location automatically after verification on a schedule of 2-4 times per day.
- Critical results will be called ASAP. If the outreach client is closed the result will be called to the appropriate on call physician, if known; or as soon as the client is again open for business. (See "Read Back" policy above)
- Clients may request our laboratory to forward test results to another healthcare provider. Avera St. Luke's Hospital requires a contact person, the business name and address, a telephone number and a secured fax number to send results to. This is necessary to have on file for HIPPA compliance.

Test Turn-Around-Time (TAT) Guidelines:
Reporting TAT's vary in the type of reporting chosen to specifically meet the individual needs of the customer. Mailed or hand-delivered reports may slightly increase the result TAT as compared to electronic or direct reporting mechanisms. The individual test listing section of the on-line Test Catalog will give general guidelines as to when the analytical procedure is performed and when reporting will occur shortly thereafter. If testing results are needed and have not been final reported to the ordering customer, results may be obtained by calling your Service Center's Client Service Department.

Reporting of results should occur within the following time frames. If the results cannot be reported within this time, the appropriate floor/unit should be notified of the delay and estimated result time:

- STATS… < 1 hour
- Now/ASAP… < 1 hour
- Routine… if delayed >24 hours
- Testing that requires > 6 hours to perform or specimens that are sent to reference labs do not fall under these restrictions.

Blood Products and Components at Avera St. Luke's Hospital

Avera St. Luke's Hospital has a contractual agreement with a blood supplier, Fargo, ND. The blood supplier provides an inventory of blood products at Avera St. Luke's Hospital to supply the transfusion needs at Avera St. Luke's Hospital. The blood supplier is available to process and deliver blood products 24/7, 365 days a year.

Avera St. Luke's Hospital Laboratory keeps the following products on site:

Leukoreduced Packed Red Cells

O positive
O negative
A positive
A negative
B positive

Fresh Frozen Plasma

type O
type A
type AB
type B

Platelets

Cryoprecipitate

Special request blood products require additional time to test or modify the blood product. Blood products considered special requests would include, but not limited to phenotyping, CMV negative, irradiated, etc. If the blood product is currently in UBS's regional inventory, the product can be available at Avera St. Luke's Hospital in less than 24 hrs. If the product needs to be harvested from a donor or shipped from another blood bank's special reserve, the process may take up to 72 hrs before it is available.

Critical Value Reporting:

When critical values are obtained during the testing process, Client Service or Technical personnel will call results to the appropriate care provider. If the patient has been dismissed, the result will be called to the physician or their designee. In the event that critical values are obtained during hours or days when a client facility is not open or the physician cannot be reached, the result will be called to the on call physician, if known, or the pathologist on call and a phone call will be placed to the client facility during the next available business day.

Critical values are also "flagged" on the test report, so in the event that reports are directly transmitted to facilities via faxes, printers, or electronic systems, it is the responsibility of the receiving facility to closely review the reports being received for critical values.

Test Cancellations:
Avera LabNet Service Centers will accept requests for test cancellation received from the originating client prior to the testing being completed. The client will not be charged for the testing cancelled. The specific information relating to the test cancellation will be documented appropriately. Requests for test cancellation received after testing is completed cannot be honored; the test will be reported and the client will be charged appropriately.

Verbal orders for laboratory tests are permitted by *Avera LabNet* Service Centers only if the ordering physician or authorized individual agrees to complete written authorization for the test request within an acceptable time frame.

Specialized Reporting Requests:
To serve our customers individualized needs specialized reporting requests will be honored. **It is the responsibility of the customer to clearly document on each test request complete instructions for the specialized reporting requested such as "call results to" or "copy results to".**
Instructions must clearly identify the reporting specifics required and must include complete:

- Name of facility, physician, or authorized individual to receive the report
- Fax or phone number; or
- Address, if results are to be mailed

Confidentiality of Results:
Avera LabNet Service Centers strive to maintain the confidentiality of all patient information. To ensure the appropriate release of patient results in response to a telephone inquiry, one of the following may be required:

- Specimen identification number
- Client identification number
- Name the person placing the verbal request and the phone number the results may be called to

Direct result transmission to a client's facility via fax, printer, or electronic system is considered to be a confidential transmission. Clients are requested to enforce appropriate confidentiality requirements on the receiving end.

Professional Courtesy Testing:
Federal and state regulations prohibit offering, "professional courtesy testing"; therefore, we cannot honor requests for this service.

Referral of Testing to Other Laboratories:
Testing that is not completed within our *Avera LabNet* Service Centers is referred out to approved reputable, licensed reference laboratories. These laboratories are carefully selected on the quality and service that they provide. If a client requests that testing be sent out to another laboratory when the testing is either performed on site or is routinely sent to our approved reference laboratory, our Service Center will charge an additional processing to cover special handling to the facility requesting the special referral.

Release of Patient Information:
Testing results will only be released to authorized individuals. Patient results will automatically be reported to the ordering physician or authorized individual via the reporting mechanism established with the originating client facility. If patient results need to be reported to a secondary referring physician and/or facility, a written order must be received indicating where results are to be reported. The primary ordering physician and/or facility will not release patient results to a secondary referring physician or facility without prior authorization.

Patients may directly receive their test results by completing the appropriate "Medical Release Statement".

Repeat Testing:
Repeat testing determinations are performed routinely as part of *Avera LabNet's* Service Centers ongoing quality assurance programs. This type of repeat testing is performed prior to the testing results being verified and reported.

If there are any questions relating to the validity of a result with respect to clinical findings, *Avera LabNet* Service Centers will be happy to repeat the assay at no additional charge. Please contact your Service Center's Client Service Department and request that testing be repeated. You may also be asked to provide documentation as to why you wish to have the testing repeated.

Blood and Body Fluids General Laboratory Testing

The accuracy of any laboratory test result is dependent upon the integrity of the specimen on which it is performed. This section gives guidelines to follow for collecting and transporting blood and body fluids. Specific test requirements are found in the Alphabetical Test Listing in the ALN Service Guide or the Quick reference guide following this manual. Please feel free to call your *Avera LabNet* service center with any questions.

Fasting Specimens:
An overnight (10-12 hour) fast is required for most fasting specimens. If individual tests require specific fasting requirements, the requirements will be outlined in the Collection Notes Section of the individual test listing.

Serum or Plasma:
Draw blood into tube appropriate for the test(s) required. The amount of blood should be 2.5 times the volume of serum/plasma required for testing. Allow the tube to fill properly. Tubes with anticoagulant need to be inverted up to 8-10 times dependent upon each anticoagulant to avoid clot formation. Do not shake. Centrifuge the specimen and separate the serum/plasma as soon as possible (< 1 hour from time of collection) into a plastic transport tube, being careful not to transfer any cells. Samples for potassium measurement should not be centrifuged more than once because results will be falsely increased. Carefully tighten transport cap. On the transport tube clearly identifies the specimen as serum or plasma (and anticoagulant when used). Rare

testing may require different timing from collection to sample separation. Special requirements will be clearly identified in the individual test listings under Collection Notes.

Whole Blood:
Draw blood using correct anticoagulant tube appropriate for the test(s) required. Allow the tube to fill completely and invert 8-10 times to facilitate mixing with anticoagulant and avoid clot formation. Submit original collection tube, completely labeled, for testing.

CSF:

Transfer CSF to leak proof plastic vial for transport. Conventional CSF screw cap collection tubes generally leak and are not recommended. If multiple specimens are being submitted for different types of testing, be sure to label specimen transport tubes with the original specimen container number (tube #1, tube #2, etc.). Use tube 1 for chemistry, tube 2 for microbiology, tube 3 for hematology, and tube 4 for other testing.
Specimen transport of CSF within the facility at Avera St. Luke's Hospital will be accepted in primary collection tubes as long as transported in an upright position.

Venipuncture Collection Guidelines:

- It is the policy of Avera St. Luke's Laboratory to protect employees from exposure to blood borne pathogens through Universal Precautions and compliance with the OSHA Blood borne Pathogen Standard Section 1910.1030 Assemble all supplies necessary for the venipuncture
- Properly identify the patient (See Patient Identification/Verification, this section)
- Apply tourniquet around arm, 3-4 inches above the preselected venipuncture site.
- Cleanse site with alcohol or approved site preparation solution (certain procedures will require that alcohol not be used in cleansing the site)
- Allow cleansed area to air dry to prevent burning sensation or hemolysis of specimen
- Grasp patient's arm firmly, placing thumb 1-2 inches below the chosen site to draw the skin tight (this technique will also assist in anchoring the vein for access)
- Perform venipuncture with needle bevel side up.
- Collect specimen(s) utilizing a vacuum tube system or syringe method. (See: Drawing Order For Vacuum Tube Collection System, this section) Utilize safety features of blood collecting devices.
- When using vacuum tube system for collecting the specimens, assure that all tubes containing anticoagulant are filled to required volumes (exhaustion of vacuum) and are mixed 8-10 times by gentle inversion immediately after collection. DO NOT SHAKE specimens
- If the collection of citrated specimen is performed in a manner that includes tubing with dead space, be sure to use two citrate collection tubes. One to take up the dead space and result in a partial fill and a second tube to collect a full and properly anticoagulated specimen.
- Release tourniquet as soon as possible after venous access is successful.
- Remove needle from site, apply direct pressure with cotton ball or gauze.
- Ensure hemostasis is complete before patient is bandaged. This requires pressure to the puncture to be released and a visual observation of a duration that ensures the detection of subcutaneous bleeding.

- After safety features have been activated with the vacuum tube collection set, discard without disassembly.
- After safety features have been activated for a needle attached to a syringe, remove and discard the needle and replace it with a safety-transfer device to fill the tubes.
- Label all specimens according to protocol prior to leaving the drawing area
- Blood letting devices are to be stored and disposed of in a manner that conforms to the Infection Control Manual; Standard Precautions.
- Tourniquets are either discarded when visibly soiled or cleansed with alcohol after use. Tourniquets may be used repeatedly for the same patient if kept within the room until dismissal.
- Should an adverse reaction such as weakness, sweating, dizziness, nausea, vomiting, or fainting occurs: Remove tourniquet and withdraw the needle from the arm at the first sign of an adverse reaction during the phlebotomy.
    - If nausea or vomiting occurs, make the participant as comfortable as possible, instruct them to breathe slowly and deeply, apply a cold compress to their forehead, turn their head to side and get an emesis container for a receptacle. Offer the participant a glass of water.
    - If a participant becomes faint or dizzy have them lie down or sit down with their head between their knees. If fainting occurs, place the participant on his/her back and raise their feet above the level of their head, loosen tight clothing, apply a cold compress to their forehead and check their pulse.
    - If bleeding persists from the venipuncture site, raise their arm and apply pressure.
    - Alert the Lab Manager or Lab Director and call ED in case of emergency.

Blood Drawn from Lines:
Blood drawn from lines may be used for laboratory testing except for coagulation studies. The first 5 mL of blood withdrawn from a line should be discarded prior to placing blood for testing into tubes.

- If in extenuating circumstances and blood cannot be obtained for coagulation studies from a venipuncture, a line may be used: the first 10 ml of blood must be discarded.

Blood Drawn from Arms with Intravenous Fluids
When an intravenous fluid (including transfused blood products) is being administered in a patient's arm, blood should not be drawn from that arm if at all possible. Test results from this blood may be erroneous and thus misleading to the physician. If the opposite arm is not available, you may draw from below the IV site.

Satisfactory specimens may be drawn above the IV site only if other alternatives are not possible. The following procedure should be followed.

- Ask the responsible caregiver for the intravenous infusion to turn off the IV for at least 10 minutes before venipuncture. Care should be taken to ensure that the flow has been completely discontinued.
- Perform the venipuncture.
- Document that the venipuncture was performed above an infusion site and that the infusion was temporarily stopped.

Precautions

- If after 2 unsuccessful attempts at the venipuncture, request another laboratory staff member to assess the success probability and attempt if confident of a successful blood draw. A third attempt may be tried if no other staff is available. If at that time there is no success, notify the physician of the situation.
- In general, blood should not be drawn for laboratory testing during blood infusion. If testing must be done, blood should be drawn from the arm opposite where the blood is being administered.
- Never draw on the side of a mastectomy or from the feet unless you have a doctor's order.
- If patients ask for the test results of previous lab testing, direct the question to the patient's physician. Laboratory personnel are not allowed to give out this type of information.
- Beware of the combative patient, ask for help.
- If the patient refuses to have blood drawn, DO NOT ATTEMPT TO DRAW IT. In a voluntary hospital this could result in assault and battery charges. Inform the nurse in charge and document on report or cancellation memo in computer. A new requisition will be required from the nursing service personnel if the patient changes his/her mind.

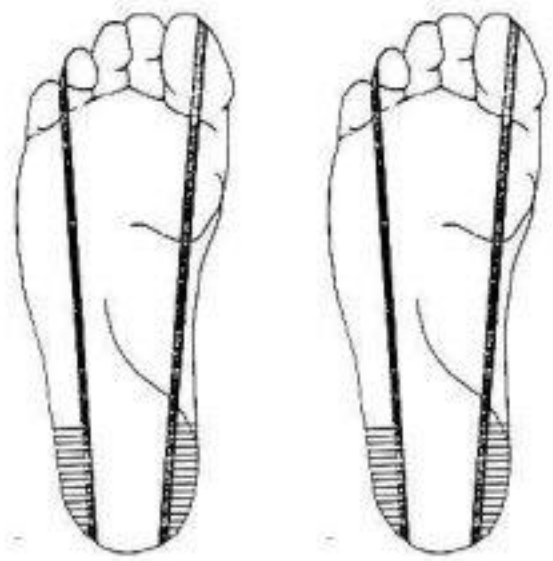
Drawing Order for Vacuum Tube Collection System:

- Culture tubes or culture vials
- Sodium-citrate tubes (light blue top)
- Serum tubes with or without clot activator, with or with-out gel separator (SST) (red, gold, speckled-stopper)
- Heparin tubes with or without gel (green)
- EDTA tubes (lavender)
- Glycolytic inhibitor (gray)

  The same order of draw should be followed when transferring blood specimens from a syringe to multiple blood-collection tubes. (NCCLS, document H3, Procedure for the collection of Blood Specimens for Diagnostic Testing by Venipuncture Dec. 2003)

Vacuum Tube System Reminders

- Use vacuum tubes that are within their expiration date and that have been stored per their manufacturer's instructions.
- Tubes with powdered anticoagulants should be tapped near the stopper to dislodge any anticoagulant that may be between the stopper and the tube wall.
- All tubes with liquid anticoagulants should be filled to the exhaustion of the vacuum to ensure proper ratio of anticoagulant to blood.



Capillary Collection Guidelines

- When it is necessary to use capillary blood for a test procedure, all reports should contain the phrase "heelstick" or "fingerstick" in the comments section.
- A single skin puncture using a lancet is sufficient for the collection of about 0.1 ml of blood in about 90% of patients.
- The typical amount of serum or plasma available from this volume blood is about 30 to 40 ul, assuming a hematocrit of 50%.
- Following skin puncture, apply pressure until bleeding has stopped. Band-Aids may be applied to all heelsticks and also to fingersticks of patients 3 years and older.
- Figure 1. Heel of neonate showing preferred site for skin puncture. (After Siumenfeid et al: Lancet h230. 1979)

Patient Identification /Verification

- When obtaining a specimen from a patient with wristband identification, compare name and birthdate on their wristband with name and birthdate with the order in hand. Also make sure SL account numbers agree.
- All in-patients and outpatients will be identified with wristband identification. Ask the patient to verbally verify his/her identity, whenever possible, at the time of specimen collection.
- Exceptions (patients without wristband identification):
    - Employee drug screen clients (identify with a photo ID or employer representative)
    - Paternity test clients (identify with a photo ID)
    - All others - identify by asking patient name and birth date

Specimen Labeling Guidelines

Label all primary specimens collection tubes with:

- Patient's name and one other identifier at the time of collection. Submitted slides may be labeled with a single identifier, but two identifiers are preferred. Examples of other acceptable identifiers include but are not limited to: date of birth, hospital number, or requisition number. Label tubes from the patient's wrist band.
- Collection date/time
- Phlebotomist name or initials.
- Sample type should be indicated on the tube.
- Proper identification of the patient and subsequent samples must begin when the specimen is collected. The identifying link; two patient identifiers and sample type, must be maintained pre-analytically, analytically, and post-analytically.

<u>Sample aliquots:</u>

- In such case that additional testing is requested, an aliquot specimen may be used if analyte integrity has been maintained and the aliquot sample has been labeled with two identifiers and sample type.

Blood Bank Specimen Labeling Requirements

Mandatory blood bank specimen labeling requirements are required. EDTA specimen must be labeled with the following information:

- patient's full name, first and last

- birthdate
- date and time specimen was collected
- initials of person that drew the blood
- blood bank identification number (BB wristband, where applicable)
- Patient location, where possible
- Medical Record Number

Samples collected for other labs
Procedure for tests not done at our facility and results not received by our facility:
- When drawing patients that come in with collection kits:
  - Courtesy collection unless we are required to ship; charge shipping as appropriate
- If drawing for a possible transplant match, no charges are to be made.

Paternity Testing
Use kits provided by the investigating agency:
Follow all collection kit instructions exactly as written.
- All individuals must be positively identified.
- Complete required information on test requisition.
- Collect samples per kit instructions.
- Label samples per kit instructions.
- Package sample and paperwork/requisition per kit instructions.
  If Payment must be made at time of collection, collect fee and complete required billing forms; if no payment is requested, complete the invoice that is included in the kit.

Specimen Storage and Transport Guidelines
Individual test listing will specify correct specimen storage and transport temperatures required.

Specimens should be refrigerated until courier pick up or mailing unless otherwise specified in the test listing. Specimens requiring refrigeration during transport should be sent with chilled "cool packs".

Certain tests will list temperature requirement as "Frozen (< -20C); Refrigerate LIMITED TIME ONLY - See Notes". This type of storage requirement will allow for storage and transport of specimen at refrigerated temperature ONLY if transport/storage of specimen will not exceed a certain time frame. If there is any possibility that time frame from specimen collection to time prepared specimen is received by the Service Center for testing will exceed time limits, please freeze specimen. Contact your Service Center with any questions relating to frozen specimen integrity.

Specimens which require freezing should be frozen ASAP in a PLASTIC TRANSPORT TUBE [unless Collection Note Section includes different instructions], allowing room for expansion during freezing. Transport with frozen cool packs in an insulated container may be adequate provided the specimen will be delivered to the Service Center within 4 hours. Otherwise, dry ice should be used in transport.

Send a separate specimen for each test requiring a frozen sample. This will prevent compromising the specimen by thawing and refreezing of the sample if testing is performed on different days or at different locations.

All specimens must be placed in a sealed leak proof biohazard transport bag prior to transporting with courier.

Unacceptable Specimen Guidelines

General Criteria for Unacceptable Specimens
Specimens may be rejected for many reasons including the following:

- Hemolysis
- Lipemia
- Insufficient Quantity (QNS)
- Improper preservative
- Unlabeled specimen
- Incorrectly labeled specimen
- Improper specimen collection or container
- Improper storage

Microbiology

- Refer to specific microbiology procedures to determine specimen acceptability.

The originating source of the specimen will be promptly notified that the specimen is rejected and determine whether re-collection is necessary. If re-collection of the specimen is not possible (spinal fluid, tissue, etc.) or if patient care would be compromised, testing may proceed only after submitting provider or nurse authenticates the specimen. A comment must be noted on the specimen report that authorization was obtained. If a mislabeled specimen is received from an outside client, and testing is requested to proceed, notify the client that a Mislabeled Specimen Authorization must be completed and returned (faxed). The test report must include a comment noting that authorization was obtained.

Glucose Tolerance

Glucose tolerance diagnostic test – For certain types of Glucose Tolerance Testings, a carbohydrate-enriched diet is recommended for 3 days prior to Glucose Tolerance Test collection. Test should be performed in the morning after an overnight fast of between 8-14 hours and unlimited physical activity. The subject should remain seated and should not smoke throughout the test.

GTT – 2 hour postload glucose: A fasting glucose blood sample is collected. If fasting glucose is greater than 126mg/dl notify the ordering physician before proceeding.

1. Administer 75 grams glucose orally over a 5 min period (for children 1.75 grams per kilogram of body weight to a maximum of 75 grams.)

2. Collect blood sample 2 hours after the administration of the glucose load.

Gestational Screen: administer 50 gram oral glucose load; collect specimen 1 hour later. If glucose is greater than 140 mg/dl, perform diagnostic GTTG.

3 Hour GTT:

1. A fasting blood sample is collected. If the fasting blood sugar is greater than 95 mg/dl, notify the ordering physician before proceeding.
2. Administer 100 gm. glucose orally over about 5 minutes.
3. Collect blood samples at 1 hour, 2 hour and 3 hours from the administration of the glucose.

Therapeutic Drug

Specimen collection and storage on a gel barrier tube can decrease the concentration of certain drugs in the specimen. Depending on the specimen volume and the storage time, the decreases may be clinically significant. We do not recommend the use of separator gel tubes for collection of therapeutic drug testing for assays that will not be tested promptly. If testing is to be delayed, pour off sample into transport vial.

Peak, Trough and Random Levels:
Reference ranges for certain therapeutic drugs are based on the time the specimens are drawn according to time guidelines around the time of the drug dose/infusion (Peak and Trough Levels). If a drug level is offered as a "Peak or Trough" level, it is recommended to follow the specimen timed drawing guidelines listed under the Collection Notes for the individual test. If the ordering physician does not specify which level to draw, contact the physician to confirm which level is clinically indicated. Random levels are recommended to only be used in cases of suspected toxicity or if the drug level required does not list specific peak and trough drawing guidelines.

Urinalysis and urine cultures

Ordering Guidelines:

- Order written as: UA or urinalysis – means UA (dipstick) without microscopic.
- Order written as: UA w/microscopic – means UA (dipstick) with microscopic
- Order written as: UA w/microscopic reflex to culture – means UA (dipstick) with microscopic + reflex to urine culture if any of the following criteria are met:
  >10 WBC per high power field

Clean Catch Urine Collection:

FEMALE
1. Wash and dry your hands.

2. Open urine collection container, placing the cap upside down so the inner surface does not touch the surface of the sink.
3. Sit on toilet.
4. Wash genital area from front to back with packaged towelettes.
5. Separate the genital folds.
6. Holding urine cup in one hand, start to urinate into the toilet. After the first part of urine has gone into the toilet, without stopping the flow of urine, put the cup under the stream of urine. Once the collection cup is ¼ to ½ full, remove the cup and finish urinating into the toilet.
7. Place lid on specimen cup.
8. Wash and dry your hands.

MALE

1. Wash and dry your hands.
2. Open urine collection container, placing the cap upside down so the inner surface does not touch the surface of the sink.
3. Wash end of penis with the packaged towelettes provided. Patient should retract foreskin before washing tip of penis. Keep holding foreskin back until urine sample is collected.
4. Holding cup in one hand, start to urinate inot the toilet.
5. After the first part of the urine has gone into the toilet, without stopping the flow of urine, place the cup under the stream of urine. When the specimen cup is ¼ to ½ full, remove the cup and finis urinating into the toilet.
6. Place lid on the specimen cup.
7. Wash and dry your hands.

Urine Specimen Stability for Urinalysis:

- Specimens are best if examined immediately after collection. If the specimen cannot be examined immediately, it should be refrigerated for preservation up to 24 hours. Allow urine specimen to return to room temperature before testing. If possible, all specimens should have the analysis completed within 2 hours of voiding. Deterioration of cellular elements and casts may begin after 2 hours. If an unacceptable specimen is received, note the reason for rejection in the computer and request a new, acceptable specimen from the patient.
- **Important**: Some urine specimens may have been collected during a critical procedure or by means of an invasive procedure; therefore, it is important to never dispose of an unacceptable specimen until the caregiver has been notified

24 - Hour Urine Collection Instructions:

- Most 24-hour urine specimens can be collected in a clean, non-metal container without preservatives if the specimen is refrigerated during the collection and transport to the laboratory. The laboratory provides 24-hour collection containers with specimen labels to record times.

  To collect a 24 hour urine specimen:

  1. Follow provider's directions regarding food, drink or drugs before and during collection.

2. Patient should empty bladder completely upon waking in the morning and discard this first urine specimen. Record the date and time under "start" on the collection container. This marks the beginning of the 24 hour collection period.
3. All urine passed during the rest of the day and night for the next 24 hours must be poured into the container.
4. Make the final collection the next morning at approximately the same time as the previous day and add it to the container. Record the time under "finish" on the collection container.
5. Transport the container to the laboratory as soon as possible.

- When the specimen is received by your laboratory:
  - Pool the entire collection into one container or completely mix the collection together.
  - Mix the specimen 15–30 times by inversion of the sealed container.
  - Measure the total volume. Read volume from the graduations provided on the container.
  - Record both the collection time and the total volume.
- If a single test is requested, refer to the test directory to determine the required submission volume, the method of preservation, and acceptable transportation conditions.
- If multiple tests are requested, more than one method of preservation may be required. Mix urine well and remove the required aliquot(s) into standard transport tubes, 4 ml should be sufficient, unless otherwise specified. Adjust the pH of the aliquots.
- Reference lab testing: Store an aliquot of the 24° urine specimen in our specimen storage rack.
- Label each aliquot with the following information:
  - Patient name
  - Patient identification number
  - Collection time and date
  - Total volume and collection duration
  - Specify preservative or no preservative pH value
  - Name of requested test

Coagulation Special Instructions:

Testing to evaluate the hemostatic mechanism is extremely sensitive to methods of sample collection and processing. Test results are a direct reflection of sample integrity. Specimens should be processed, and sent according to acceptable protocol.

Platelet-Poor Plasma Preparation – Double centrifugation Method

1. General Specimen Drawing Instructions:
   a. Vacuum tubes must be filled to completion to ensure the proper 9:1 ratio of blood to anticoagulant is achieved

b. When drawing specimen avoid contaminating sample with tissue thromboplastin or heparin as they may alter testing results:
    - Venipuncture must be clean, with no trauma
    - Hemolyzed specimens are not acceptable
    - If drawn through an indwelling catheter, the first 10 mL of blood must be discarded or used for other testing as appropriated.
    - If the collection of citrated specimen is performed in a manner that includes tubing with dead space, be sure to use two citrate collection tubes. One to take up the dead space and result in a partial fill and a second tube to collect a full and properly anticoagulated specimen.

c. Draw appropriate number of tubes to provide required volume of plasma for testing [required specimen volumes listed in "Alphabetical Test Listing".

d. Invert collection tubes gently 5-6 times to mix blood with anticoagulant. DO NOT SHAKE tubes. Process specimens immediately.

2. Centrifuge for 10-15 minutes at 3000 RPM.
3. With a plastic transfer pipette carefully remove plasma, place in a plastic tube and centrifuge again [10-15 minutes at 3000 RPM]. **Platelet-poor plasma must have a final platelet count of <10,000. Please validate centrifugation and time guidelines to your facility's equipment by completing a platelet count on a plasma specimen prepared with these guidelines. If platelet count is >10,000, adjust times, centrifuge rpm, or complete a third centrifugation step prior to submitting specimen for testing.**
4. With a plastic transfer pipette, transfer plasma to plastic transport tube being careful to avoid aspirating the buffy coat.
5. Each individual coagulation test ordered should be prepared and submitted as an individual specimen. DO NOT submit multiple test specimens in one tube. Coagulation Consultation Study testing also requires submission of "normal control specimens" – Refer to the following section on Coagulation Consultation Special Collection Instructions.
6. Label specimen. Include anticoagulant.
7. Freeze immediately at < - 20° C.
8. Specimen must remain frozen and be received within 24 hours. Specimens not received in the frozen state will be rejected for testing.
   Ship on dry ice.

Fetal Fibronectin Collection, Guidelines:

Proper specimen collection and handling is essential in providing high quality Fetal Fibronectin testing results. All individuals responsible for the collection of these specimens are requested to follow all precautions, warnings and instructions listed in the package insert of the specialized specimen collection kit.

GENERAL SPECIMEN COLLECTION PRECAUTIONS AND WARNINGS:

Specimens for Fetal Fibronectin testing should be collected prior to collection of culture specimens.

1. Specimens should be obtained prior to digital cervical examination or vaginal probe ultrasound examination as manipulation of the cervix may cause the release of Fetal Fibronectin.
2. Specimens should not be collected if the patient has had sexual intercourse within 24 hours prior to the sampling time because semen and/or sperm present in the sample may increase the possibility of the test giving a false positive result.
3. Specimens will not be tested if the specimen transport tubes have leaked in transit.
4. Care must be taken not to contaminate the swab or cervicovaginal secretions with lubricants, soaps, or disinfectants [i.e. K-Y Jelly lubricant, Betadine disinfectant, Monistat cream, hexachlorophene]. These substances may interfere with absorption of the specimen by the Dacron collection swab or with the antibody-antigen reaction of the test analysis.
5. Fetal Fibronectin tests are not intended for use in the management of patients with moderate or gross vaginal bleeding. The presence of vaginal bleeding judged by the caregiver to be moderate or gross in amount may contribute to difficulty in interpreting the analytical result.

6. Rupture of membranes should be ruled out prior to specimen collection since Fetal Fibronectin is found in both amniotic fluid and the fetal membranes.
7. Specimens should not be obtained from patients with suspected or known placental abruption, placental previa, or patients with cancers of the reproductive tract.
8. There is insufficient information characterizing the association of Fetal Fibronectin expression to delivery in asymptomatic women with HIV/AIDS.
9. Store and transport specimens according to test catalog information.
10. Use only one Specimen Collection Device per patient sample and DO NOT use collection kits past their expiration date.

FETAL FIBRONECTIN GENERAL COLLECTION INSTRUCTIONS:

1. Always use special collection kits specific for Fetal Fibronectin testing and follow Specimen Collection Kit specific instructions.
2. Collection from Symptomatic Women:
   During sterile speculum exam, prior to any examination or manipulation of the cervix or vaginal tract, lightly rotate the collection kit swab across the posterior fornix of the vagina for approximately 10 seconds to absorb cervicovagninal secretions. Subsequent attempts to saturate the swab may invalidate the test.
3. Collection from Asymptomatic Women:
   During sterile speculum exam, prior to any examination or manipulation of the cervix or vaginal tract, lightly rotate the collection kit swab across either the posterior fornix of the vagina or the ectocervical region of the external cervical for approximately 10 seconds to absorb cervicovaginal secretions. Subsequent attempts to saturate the swab may invalidate the test.
4. Remove swab and immerse Dacron tip in buffer. Break the shaft [at the score] even with the top of the transport tube.
5. Align the shaft with the hole inside the tube cap and push down tightly over the shaft, sealing the tube. WARNING – the shaft must be aligned to avoid leakage of the specimen.
6. Specimens must be stored at refrigerated temperatures and have testing completed within 3 days of collection. Do not collect specimens after routine courier pickups on Fridays or prior to extended holiday weekend

FETAL FIBRONECTIN INDETERMINATE TEST RESULTS – CAUSES AND ACTIONS:
On rare occasions, the testing of a fetal fibronectin specimen will result in an "indeterminate or Invalid" reading on the instrument used for testing. In this instance, the method is unable to Determine if the specimen is positive or negative for fetal fibronectin.

Possible reasons for "invalid/indeterminate" results include the following:
1. Atypically high concentration of fibronectin due to a presence of amniotic fluid. (The assay is intended to be used on women with intact fetal membranes.)
2. Interfering substances (may include soaps and lubricants) are present in the specimen.
3. Sample matrix abnormality.

Fecal Specimen for Occult

In general, patients should be carefully instructed to not ingest foods and vitamins which can cause falsepositive or false-negative test results.
Patient should avoid the following 7 days prior and during testing: • No more than one adult aspirin (325 mg) a day • No other non-steroidal anti-inflammatory drugs such as ibuprofen (Motrin, Advil) Patient should avoid the following 3 days prior and during testing: • No red meat (beef, lamb, or liver) • No more than 250 mg vitamin C a day from supplements, and citrus fruits and juices.
Substances that can cause false-positive test results:
• Red meat (beef, lamb, and liver) • Aspirin (greater than 325 mg/day) and other non-steroidal anti-inflammatory drugs such as ibuprofen, indomethacin and naproxen. • Corticosteroids, phenylbutazone, reserpine, anticoagulants, antimetabolites, and cancer chemotherapeutic drugs • Alcohol in excess The application of antiseptic preparations containing iodine (povidone/iodine mixture)
Substances which can cause false-negative test results
• Ascorbic acid (vitamin C) in excess of 250 mg/day • Excessive amounts of vitamin C enriched foods (citrus fruits and juices) • Iron supplements which contain quantities of vitamin C in excess of 250 mg/day

Applying feces to the Hemoccult slide:
1. Using an applicator stick, collect a small fecal specimen and apply a thin smear covering box A.
2. Reuse applicator to obtain a second sample from a different part of the fecal specimen. Apply a thin smear covering box B.
3. Close cover flap.
4. Label slide with patients name and date of birth.
5. Dispose of applicator in waste container.
6. Transport slide to the laboratory for testing.

Fecal Specimen for iFOB (immunochemical Fecal Occult Blood)

The iFOB test has been designed to be more specific in detecting low levels of human fecal occult blood. The results of immunochemical FOB rapid tests are not affected by dietary peroxidases, animal blood or ascorbic acid.

Specimen Collection and Storage:
Note: Do not allow fecal specimen to contact toilet water until after the sample has been collected. Do not urinate on fecal specimen.

1. Label the collection tube with appropriate patient identifiers.
2. Deposit fecal specimen on collection paper or in a clean dry container.
3. Unscrew the sampler from the collection tube.
4. Randomly pierce the fecal specimen with the grooved end of the sample in at least five different sites.
5. Insert the sampler into the collection tube and firmly tighten it.
6. Shake the collection tube to mix the fecal specimen and the FOB buffer.
7. Transport specimen to the laboratory for testing.

Note: Specimens collected may be stored up to 8 days at ambient temperatures below 35°C, 6 months at 2°-8°C, or 2 years at -20°C.

Microbiology Collection Guidelines & Special Instructions:

Microbiological procedures used are those recommended by the American Society for Microbiology, American Society of Clinical Pathologists, College of American Pathologists, and National Committee for Clinical Laboratory Standards.

For the collection and evaluation of microbiology specimens, it is necessary to understand that any given body site develops its own "usual/normal" flora. When collecting cultures from sites, special care must be taken to bypass contaminating flora. Examples of such sites are skin, upper respiratory tract, intestinal tract, female genital area, and open draining wounds. Submit aspirated material whenever possible.

Culture Collection Basics:

- Collect the specimen at optimal times and prior to antimicrobial therapy, if possible.
- Collect sufficient quantity.
- Use proper collection containers and transport media. Always assure that transport containers are leak proof.
- If required, prepare site to assure uncontaminated collection. Submit aspirated material whenever possible.
- Indicate source and collection time information on the requisition and/or specimen.
- Minimize transport time. The survival of bacteria in a transport medium depends on many factors. These include the types of bacteria, duration on transport medium. Culture transport devices maintain viability of many microorganisms for 24-48 hours. For fastidious bacteria,

such as Neisseria gonorroheae and Streptococcus pneumoniae, swab specimens should be plated directly onto culture medium or transported immediately to the laboratory and cultured within 24 hours.

Reflex Testing General Guidelines:
Certain microbiology procedures require reflex testing to be completed to provide appropriate information to the ordering physician to allow for result interpretation and therapy intervention decisions to be made.

Reflex Testing Guidelines are identified under each test in the "Alphabetical Test Listing". Reflex testing completed will be individually billed.

Examples of reflex testing on potential pathogenic cultures include, but may not be limited to:
- Bacterial Identification(s)
- Susceptibility Testing(s)
- Monoclonal Testing(s)

It is the responsibility of the ordering physician to specifically order "reflex testing is not to be completed" if at the time of the test request reflex testing is not clinically indicated.

If reflex testing is not required due to culture results or if the physician has specifically requested, testing will not be completed or billed.

Microbiology Routine Culture Collection Guidelines:

Aerobic Culture:
- Tissue or aspirated specimens submitted in a sterile leak proof container. If unable to collect one of the specimens listed a culturette transport swab or and E swab is acceptable.
- Label specimen with patients name and date of birth
- Specific site on test request
- Transport to laboratory as soon as possible. Fastidious microorganisms should be transported to the laboratory within 24 hours ambient temperature.

Acid-Fast Bacilli Culture and/or Smear:
Refer to South Dakota Public Health Laboratory Medical Microbiology Service Manual for specific specimen guidelines:
https://doh.sd.gov/lab/assets/MedProcedureManual.pdf

Anaerobe Culture:
- Aspirates, body fluids, tissues, or material collected from areas without normal anaerobic flora submitted in a sterile leak proof container. If unable to collect one of the specimens listed, a culturette containing amies clear media or an E swab is acceptable.
- Label specimen with patient name and date of birth.
- Specify site on test request
- Specimen should be transported to the laboratory as soon as possible.

Unacceptable Anaerobe Culture Sources/Sites:

- Abscesses of bowel origin including appendiceal and perirectal abscesses
- Feces, rectal swabs and colostomy discharge [when clinically indicated, these types of specimens may be used for the diagnosis of botulism and for intestinal disease caused by Clostridium difficile and Clostridium perfringens]
- Gastric specimens
- Superficial skin lesions, skin ulcers and pilonidal sinus
- Abdominal wounds contaminated with feces [eg. open fistulas] and exudative wounds not properly collected [must exclude skin contamination]
- Surgical drain sites
- Voided or catheterized urine and Foley catheter tips
- Vaginal or cervical specimens including lochia
- Prostatic or seminal fluid
- Throat and nasopharyngeal swabs and oral secretions
- Sputum and bronchoscopy specimens
- Gingival swabs

Blood Culture: (Bacterial or Fungal)

Bottles required per set of blood cultures:
Adult: 1 aerobic blood culture bottle 1 anaerobic blood culture bottle
Pediatric: 1 Pediatric blood culture bottle

1. Inspect each blood culture bottle before use to ensure integrity of bottle and sensor on the bottom of bottle is intact.
2. Ensure the sensor on the bottom of the blood culture bottle is uniform grayish-green color.
3. Discard any bottle found to be damaged or with a sensor that is yellow.
4. Remove protective flip top cap
5. Cleanse the rubber septum with a 70% isopropyl alcohol wipe and let air dry
   Important: The rubber septum is not sterile and must be disinfected

6. Confirm patient identification.
   Note: Resolve all patient identification discrepancies prior to specimen collection.
7. Assemble necessary supplies (per manufacturer's instructions) and select the appropriate tubes according to test requests
8. Apply latex-free gloves
9. Apply tourniquet 3-4 inches above the bend of the arm.
10. Select a vein by identifying the most prominent of acceptable veins in the antecubital area (median, cephalic, and basilic) visually and by palpation.
11. Cleanse the skin using a 70% isopropyl alcohol prep to remove surface contaminants of the skin.
12. Using a ChloraPrep scrub the intended venipuncture site for 30 seconds moving outward in a concentric spiral.
    Note: Use iodine prep on children <2 months of age
13. Allow venipuncture site to air dry.
    Note: If re-palpation of vein is required, the site must be re-cleansed
14. Insert the needle into the prepared vein.

15. Collect the blood sample. Release tourniquet once blood flow is established.
16. Transfer up to 10 mL of blood into the anaerobic blood culture bottle.
17. Next, transfer up to 10 mL of blood into the aerobic blood culture bottle.
    Warning: Never force syringe plunger down during inoculation, as splashing of the sample may occur.
18. If blood is required for other laboratory tests, collect according to Vacutainer Order of Draw Guide.
    Important: If other blood tests are requested, always collect the blood culture first.
19. Place gauze over the venipuncture, remove needle, and activate safety shield.
20. Instruct patient to apply pressure to gauze over venipuncture site.
21. Discard syringe into the sharps container.
22. Appropriately label all collected specimens.
23. Apply bandage to venipuncture site after bleeding has stopped.
24. Transport specimens to laboratory.

Important: The volume of blood obtained for each blood culture set is the most significant variable in recovering microorganisms form patients with bloodstream infections.
Adult: Minimum recommended fill 5mL per bottle; Maximum recommended fill 10 mL per bottle
Pediatric: Minimum recommended fill 1 mL per bottle; Maximum recommended fill 4 mL per bottle.

Chlamydia Culture:
Refer to ARUP Laboratory Test Directory for specific specimen guidelines:
http://ltd.aruplab.com/Tests/Pub/0060850

Chlamydia by Amplified detection:
Refer to Avera Laboratory Network-Sioux Falls Test Directory for specific specimen guidelines:
https://www.testmenu.com/averamckennan/Tests/300546

Chlamydia by Amplified detection-Urine Specimen Collection Guide
https://www.avera.org/app/files/public/13777/Aptima_Urine_Specimen_Collection_Guide.pdf

Fungal Culture, other than skin, hair, nail
Refer to Avera Laboratory Network-Sioux Falls Test Directory for specific specimen guidelines:
https://www.testmenu.com/averamckennan/Tests/301026

Fungal Culture, skin, hair, nail
Refer to Avera Laboratory Network-Sioux Falls Test Directory for specific specimen guidelines:
https://www.testmenu.com/averamckennan/Tests/300959

Genital Culture:
- Collect vaginal, cervical, urethral, epididymitis, prostatitis (throat for GC only) specimen using a swab from a culturette collection swab. Eswab also acceptable.
- After collection, insert the swab into culturette holder.
- Specify collection site.

- Label specimen with patient name, date of birth, and specimen site.
- Ship at ambient temperature.

For GC culture only, submit an inoculated Modified Thayer-Martin plate or swab at room temperature, do not refrigerate

Urogenital Group B Strep collection:
- Swab the lower vagina, followed by the rectum (i.e., insert swab through the anal sphincter) using the same culturette swab. Culture should be collected in the outpatient setting by the health-care provider.
- Label specimen with patients name and date of birth.
- Cervical, perianal, perirectal or perineal specimens are not acceptable, and a speculum should not be used for culture collection.
- Transport to the laboratory ambient within 48 hours. Specimens that are delayed >48 hours should be refrigerated

Nasopharyngeal Specimen Collection:
- Open swab package and remove swab.
- Hold the swab in your hand, pinching in the middle of the swab shaft.
- Gently insert the swab into the nostril until you touch the posterior nasopharynx.
- Rotate the swab several times.
- Withdraw the swab from the patient's nostril.
- Place swab in appropriate transport system.
- Label specimen with patents name and date of birth.

Nasopharyngeal aspirate Collection:
1. Attach catheter to suction apparatus.
2. Tilt patient's head 70°
3. Instill several drops of sterile saline into each nostril.
4. Place catheter through nostril to posterior nasopharynx
5. Apply gentle suction. Using rotating motion, withdraw catheter.
6. Label specimen with patient name, date of birth, medical records number and specimen source.
7. Immediately transport specimen to laboratory for testing.
8. Store and transport specimen at 2-8°C

Neisseria Gonorrhea by Amplified detection:
Refer to Avera Laboratory Network-Sioux Falls Test Directory for specific specimen guidelines: https://www.testmenu.com/averamckennan/Tests/300943

Nose Culture:
- Open the swab package and remove the swab.
- Hold the swab in your hand pinching the middle of the swab shaft.
- Insert swab into the patient's nostril 1-1.5 cm

- Rotate the swab against the inside of the nostril for 3 seconds while applying pressure with a finger to the outside of the nostril.
- Repeat process on the other nostril with the same swab.
- Withdraw the swab from the patient's nostril.
- Place swab in appropriate transport system.
- Label specimen with patients name and date of birth.

Sputum Culture:
- Patient should gargle and rinse mouth with water prior to collection.
- Patient should cough deeply.
- Once sputum is in the patient's mouth, have the patient release it into the leak proof specimen container.
- Label specimen with patients name and date of birth
- Transport to laboratory as soon as possible. If testing will be delayed >2 hours the specimen should be refrigerated.
- All sputum specimens will be Gram stained and evaluated for acceptability. Specimens that are not acceptable per policy will be rejected.

Stool Specimen:
1. Label each container with patient name, date of birth, and date of collection.
2. Collect the fecal sample in the specimen collection container provided by the laboratory. Avoid contamination with urine.
3. When opening container(s) to add stool do not remove liquid inside.
4. Stool should be added to each container containing liquid to bring liquid levels up to the "fill to here" line.
5. Add 5 to 8 grams of stool to each container not containing liquid.
6. Place cap on each collection container. Tighten the caps and mix each container to insure the specimen is adequately mixed.
7. Place containers into the plastic biohazard bag and transport to laboratory. C&S transport media should be transported ambient within 96 hours.
8. Fresh, unpreserved specimens should be sent to the lab as soon as possible. Unpreserved stool cannot be cultured >2 hours from collection.

Spinal Fluid (CSF) or Other Body Fluids:
- Body fluids should be collected in appropriate sterile tubes.
- Transport to laboratory as possible.

If spinal fluid is to be submitted, collect at least 1 mL of CSF; 2-3 mL is preferred

Throat Culture:
- Remove swab from package.
- Hold the swab in your hand placing your thumb and forefinger in the middle of the swab shaft.
- Gently swab the posterior pharynx, tonsils or other inflamed areas. Avoid touching the tongue, cheeks, and teeth with the swab when collecting the specimen.
- Label specimen with patients name and date of birth

- Ship specimen at ambient or refrigerated within 48 hours
  Limitation: culture for beta-hemolytic Streptococcus only. If other organisms are to be cultured, list on test requisition. If GC is suspected order "GC only culture."

Urine Culture:
- Preferred specimens include: first morning specimen collected as a clean-catch midstream specimen or catheterized specimen. All non-catheterized specimens should be collected as clean-catch midstream specimens.
- Patient instruction on correct procedure to follow for obtaining a midstream collection is very important
- Label specimen with patients name and date of birth.
- Transport refrigerated 24 hours or in a urine transport media tube ambient 48 hours.

Vaginal Wet prep; KOH
- Vaginal fluid collected on a sterile swab. If the specimen requires transportation, the specimen should be placed in approximately 0.5 mL of saline and transported to the laboratory at room temperature.
- Label specimen with patients name and date of birth.
- Wet preparation includes: exam for Trichomonas, clue cells, WBC's, and fungal elements.
- KOH: includes exam for presence of fungal elements.

Wound Culture
- Tissue or aspirated material submitted in a leak proof container, a culturette transport swab or an E Swab. After collection, insert the swab into the transport container.
- Label specimen with patients name and date of birth.
- Ship at ambient temperature.
- Indicate culture source on test request.

PARASITOLOGY COLLECTION

Pin Worm:
Refer to Avera Laboratory Network-Sioux Falls Test Directory for specific specimen guidelines: https://www.testmenu.com/averamckennan/Tests/299884

Ova & Parasite Extensive Panel General Instructions:

- Patient instruction on correct procedure to follow for obtaining specimen utilizing the appropriate ova & parasite collection system is very important. Package inserts or collection instructions below next page may be copied and used for patient instruction as needed.
- The patient should be cautioned against the use of antacids, barium, bismuth, antidiarrheal medication, or oily laxatives prior to collection of the specimen.
- The patient should be reminded that the specimens collect should not come into contact with urine or toilet water.

- To assure recovery of parasitic elements that may be passed intermittently and in fluctuating numbers, it is recommended to collect three specimens on different days [multiple specimens should not be collected on the same day]. The number of specimens to be tested must be defined by the ordering physician.

Patient Ova & Parasite Collection Instructions:

IMPORTANT:
Please Read All Instructions Before Specimen Collection Is Completed

You have been given a collection kit, which will help you conveniently collect a stool specimen for testing that your physician has ordered. All directions must be closely followed to assure the best possible specimen for testing. The kit you have been given may include multiple containers. Please be sure that you have put some of your specimen in all the tubes. If you are instructed to collect multiple specimens on different days, you will be given the appropriate number of collection kits for the days required.

CAUTION:
- Solutions in the collection containers are poisonous. DO NOT DRINK. Keep them out of the reach of children.
- Antidote If Swallowed: Dilute by drinking 2-4 glasses of water. Immediately contact an emergency facility, poison information center or a physician to receive medical attention. Save the collection container; label information will be helpful for determining appropriate medical treatment.
- If any liquid from the collection containers gets on your skin or in your eyes, flush with plenty of water. If irritation develops, consult your physician.

Collection Instructions:

1. The stool should be passed into a clean, DRY container. Use a bedpan or place a large plastic bag into a wastebasket to catch the specimen. A clean margarine tub, clean wide-mouthed jar or clean milk carton with the top cut off can also be used.
2. Do not urinate in the container. The stool specimen must not come into contact with urine or toilet water. Do not pass the specimen directly into the collection kit containers.
3. After the stool is collected, open the kit container. Using the collection spoon built into the lid of the container place small scoopfuls of the stool from areas which appear bloody, slimy or watery into the container. If the stool is formed [hard], please try to sample small amounts from each end and the middle. Continue to add specimen level reaches the "fill to here" line or indicator. DO NOT contaminate the outside of the collection container with the stool sample.
4. Mix the stool sample with the liquid in the container with the spoon. Twist the cap tightly closed and shake the container vigorously until the content is well mixed.
5. Repeat steps 3 and 4 until all kit containers have been filled with stool specimen. After all containers have been filled, the remaining stool specimen may be discarded.

6. Double check all caps to be sure they are tightly closed.
7. Fill in all information required on each container. Be sure to check the box on the container which describes the consistency of the specimen you collected. [Formed = distinct shape and hard; Soft = distinct shape but soft; Loose = no distinct shape, thick sludge-like; Watery = very loose, liquid-like]
8. Wash hands thoroughly after collection is complete.
9. Store collected specimens at room temperature and return them to the laboratory as soon as all required specimens have been collected.

Virology Collection Guidelines

Refer to Laboratory Test Directory for specific specimen collection guidelines:
Culture site is required for processing.
Please note specimen stability.

Viral Culture, Respiratory
http://ltd.aruplab.com/Tests/Pub/2006499

Viral Culture, Non-Respiratory
http://ltd.aruplab.com/Tests/Pub/2006498

Herpes Simplex Virus Culture
http://ltd.aruplab.com/Tests/Pub/0065005

Respiratory Viruses by DFA
http://ltd.aruplab.com/Tests/Pub/0060289

Respiratory Comprehensive Panel by PCR
https://www.testmenu.com/averamckennan/Tests/527225

Respiratory Virus Panel by PCR
https://www.testmenu.com/averamckennan/Tests/527224

Anatomic Pathology

1. **Specimen identification and General Requisition Requirements**
   - **a.** Outreach facility requisitions must include the following information:
     - Patients full Name
     - Address
     - Social security number
     - Date of birth
     - Sex
     - Name of submitting facility, place of service
     - Surgeon or Physician's Name

- Clinical history (e.g previous malignancies, radiation or chemotherapy treatment, previous abnormal paps)
- Insurance and/or billing information
- Date of collection
- Specimen source

b. Hospital inpatient Surgical Pathology Requisitions must include the following information:
- Patient's full name
- Date of birth
- Sex
- Department location, place of service
- Surgeon's or Physician's name
- Clinical history (e.g previous malignancies, radiation or chemotherapy treatment, previous abnormal paps)
- Pre-Operative diagnosis
- Operative findings
- Tissues submitted
- Specimen source
- Time and date of collection
- Hospital Identification Number

2. <u>One Specimen, Multiple Tests</u>

It is recommended that specimens requiring both Pathology and Microbiology Culture testing be divided in the field. If dividing the specimen in the field is not possible, it is recommended that staff collecting the specimen consult with the Pathology department for handling instructions. It is important that formalin is not added to any specimen requiring Microbiology culture including but not limited to; gram stain, aerobic culture, anaerobic culture, fungal culture, viral culture, AFB culture and smear. Microbiology cultures cannot be performed on any specimen where formalin has been applied.

3. <u>Surgical Pathology Specimens</u>

- Surgical tissue specimens are obtained for diagnostic evaluation of benign or malignant neoplasms and/or inflammatory or infectious diseases. The collection of tissue may be performed in a variety of ways.
- Tissue specimens are placed in 10% formalin unless otherwise indicated. See <u>One specimen, Multiple Tests</u> section.
- Specialized tests may require fresh tissue, frozen tissue, or tissue submitted in another fixative. Specialized test requests may require consultation with the Pathology Department for additional specimen collection instructions.
- All specimen containers must be appropriately labeled with patient identifiers.
- Each specimen must be accompanied by a completed requisition. Refer <u>to Specimen identification and General Requisition Requirements</u> section.
- All specimens will be transported to the Pathology Department for testing.

4. Expedited Cases

Frozen Sections/ASAP Specimens:

It is preferred that frozen sections are scheduled at least a day before the surgery by indicating it on the operating schedule or by a phone call to pathology to ensure a pathologist will be available. In the event of needing a frozen sections unexpectedly, call Pathology at 605-622-5061 or 605-622-5065 immediately indicating the necessity.

The specimen is placed in a properly labeled dry container. The specimen should be accompanied by a requisition indicating immediate examination results are desired. Follow guidelines for completing requisitions as listed in the Specimen identification and General Requisition Requirements section.

Pathologist will inform the physician/surgeon by phone when he/she is finished examining the specimen.

5. Products of Conception and Fetuses

Products of conception are retained by the Pathology Department for periodic mass burial arranged by a local funeral home.

If the family requests the POC/Fetus for private burial, the remains are released from the Pathology Department upon receipt of a completed **Specimen Release Form**.

6. Cytopathology

Requisition:

Each cytology specimen must be accompanied by a completed requisition. Follow guidelines for completing requisitions as listed in the Specimen identification and General Requisition Requirements section.

Non-gynecological specimens:

- Type of specimen submitted
- Prior cytology and/or biopsy correlation is applicable
- Previous history or carcinoma, radiation or drug therapy

Gynecological specimens:

- Type of specimen submitted
- Clinical history: LMP, pregnancy, post-partum, post abortion/miscarriage, hormone therapy, abnormal bleeding, previous abnormal smear, previous dysplasia/gyn carcinoma. Total hysterectomy, supracervical hysterectomy, cryosurgery/radiation, or other.

Collection Procedures for Non-Gynecologic Specimens

Bronchial brushings

Following collection, immediately place the brush in the bronchial washing container and swirl vigorously to dislodge the material into the container. Discard brush. Label the jar with the patient's name, DOB and the specimen site.

Bronchial washings
Collect specimen in bronchial washing container. Label the jar with the patient's name, DOB and the specimen site.

Body Fluids/Cyst Fluids
Paracentesis, Pleural, Peritoneal, Pericardial, Thoracentesis, Ovarian Cysts

A minimum of 10 mL of specimen is recommended. Heparin may be added to the specimen to reduce clotting. Place 1 cc of heparin per 100 mL of fluid and gently agitate to thoroughly mix the specimen and heparin. Specimens should be refrigerated until pickup. If transport of the specimen will be > 72 hours after collection, add equal amounts of cytology fixative (if the specimen size is too large to accommodate this volume, a well-mixed aliquot of the specimen with an equal volume of cytology fixative many be utilized). The entire volume of fluid collected and any aliquot(s) of the specimen should be transported to the Pathology Department for examination. Large collapsible plastic containers should be placed in a large Ziplock biohazard bag for transportation.

Body Fluid Specimen requirements:
A minimum of 10 mL of specimen is recommended. If fluid is collected for other testing in addition to cytology, e.g. cultures, chemistry, etc., other tests >10 mL of specimen is recommended.

Sputum
Provide the patient with a screw top collection container. Instruct patient to cough deeply and expectorate deep cough material into the container. Label the container with the patient's name and DOB. See **Instructions for the Collection of Sputum** for more specific instructions.

<u>Instructions for the Collection of Sputum</u>
Supplies needed:
Sterile container, labeled with the patient's name and DOB.

Procedure:
1. Upon awakening, clear the throat of any material which may have accumulated overnight and discard.
2. Rinse mouth out with water several times.
3. Cough deeply several times during the next hour
4. Deposit whatever you raise from the lungs into the specimen cup provided. The material needed for the test is the material coughed up from deep in the lungs, not saliva from the mouth.
5. After collection, bring specimen to the doctor or laboratory as soon as possible. If there is a delay in returning the specimen to your doctor or laboratory, place specimen in refrigerator.
6. If your physician has ordered a sputum x3, do this for three consecutive morning into consecutively labeled containers (#1, #2, #3). Bring container to the doctor or laboratory

as soon as possible after collection each day. If there is a delay in returning the specimen to your doctor or laboratory, place specimen in refrigerator.
7. If your physician has ordered a pooled sputum, do this for three consecutive mornings into the same container. Place specimen in the refrigerator. After collection on the third day, bring specimen to the doctor or laboratory as soon as possible
8. If collection is over a weekend, store specimen in refrigerator until you are able to bring specimen to the doctor or laboratory.
9. If you have any questions about which type of sputum specimen your physician has ordered, please clarify with him/her before proceeding.

Cerebrospinal Fluids:
Fresh specimens must be delivered to laboratory within 20 minutes of collection. If there is a delay, (out of town facilities) add the specimen to a small screw top container with cytology fixative for preservation. Label container with patient's name, DOB and specimen site.

SurePath Thin-layer Pap Test System
1. Position tip of longer bristles in cervical os. Begin rotating in clockwise direction. Bristles will begin to stiffen.
2. Continue rotating in a clockwise direction and gently push towards the cervix until the shorter bristles begin to bend extending over the ectocervix.
3. Complete five - 360° rotations. Remove device, pop off "broom" head into the SurePath test vial.
4. Label vial with patient name and date of birth.

Thinprep Pap Test Collection Guidelines
Proper sample collection is very important, especially proper rinsing of the devices in the ThinPrep vial. Do NOT leave the collection device in the vial.

Cytobrush Plus GT cell collector and spatula
1. To collect specimen from exocervix, select contoured end of plastic spatula and rotate it 360° around the entire exocervix while maintaining tight contact with exocervical surface. Remove spatula.
2. Rinse contoured end of plastic spatula in a vial of PreservCyt solution by swirling vigorously 10 times. Discard plastic spatula. Place cap on vial until step 4.
3. Insert Cytobrush Plus GT device into the endocervix until only the bottom most bristles are exposed. Slowly rotate ¼ to ½ turn in one direction. Remove device.
   <u>Do not over-rotate. Additional rotating may cause bleeding and contaminate the specimen.</u>
4. Rinse the Cytobrush Plus GT device in the PreservCyt solution by rotating the device in the solution 10 times while pushing against the wall of the vial. Swirl the device vigorously to further release material. Discard device.
5. Tighten the PreservCyt vial cap so that the torque line on the cap passes the torque line on the vial.

Papette Brush
1. Contact the cervix with the Papette brush and insert the central bristles into the cervical canal deep enough to allow the shorter bristles to fully contact the ectocervix. Be sure

not to force the shorter bristles into the cervical os to prevent unintended separation of the brush from the handle.

2. While maintaining gentle pressure in the direction of the cervix, rotate the brush 5 times in either direction.
3. Rinse the brush into PreserveCyt solution by pushing the brush into the bottom of the vial 10 times, forcing the bristles apart. Swirl the brush vigorously to further release material. Discard the collection device.
4. Tighten the PreservCyt vial cap so that the torque line on the cap passes the torque line on the vial.

References:

CLSI H 18-A4 Vol 30 No. 10; Procedures for Handling and Processing of Blood Specimens for Common Laboratory Tests: Approved Guideline-4th Edition; CLSI GP 33-A Vol 29 No. 13 Accuracy in Patient and Sample Identification: Approved Guideline ; CLSI H3-A6 Vol 27 No. 26 Procedures for the Collection of Diagnostic Blood Specimens by Venipuncture- Approved Standard – 6th Edition.

Acct#_____
(For ASL lab use only)

Avera LabNet

Check the appropriate box

Additional Test Request ☐

Verbal Order Verification ☐

Avera St. Luke's
Aberdeen Service Center
305 South State St.
Aberdeen, SD 57401
605-622-5546 or 1-800-225-8537
FAX:605-622-5266

Facility: _____**Dr.**_____

Patient Name:
_____

Date of Birth:_____ **SS #:**
_____

Bill to:
Facility [ ] Medicare [ ]
#_____

Insurance [ ]
Name_____**#**_____

Collection Date:
_____

Caller:
_____

Date of call:
_____

Test(s) Requested:
_____**Diagnosis:**_____

Fax Results Order ☐

Fax Request:
Fax Results to: Name:_____**Fax number:**_____

Federal Regulations state: The laboratory must perform tests only at the written or electronic request of an authorized person. Oral requests for laboratory tests are permitted only if the laboratory subsequently obtains written authorization for testing within 30 days of the request.

Mislabeled Specimen/Requisition Authorization

Testing requested to be performed under (name):
_____

Requisition labeled as: _____ **Client:**
_____

Specimen labeled as: _____ **Client contact:**
_____

Specimen date: _____ **ASL Rep:**
_____

Comments:_____
_____

Client please have physician sign and then return by fax to 1-605-622-5266.
Physician Signature_____ **Date**
_____

Sponsored by the Benedictine
And Presentation Sisters

305 South State Street
Aberdeen, SD 57401
(605) 622-5000

www.averastlukes.org

Medical Record # _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Birthdate _____

Maiden/Other Name _____ Social Security # _____

I hereby request and authorize:
Name of Facility/Person_____

Address _____

To release information from my health record to:
Name of Facility/Person _____

Address _____

Please release the following information:

Dates of Service _____		
___ Discharge Summary ___ History & Physical ___ Consultation	___ Operative Report ___ Emergency Report ___ Laboratory Report	___ X-ray Report ___ EKG Report ___ Pathology Report
___ Other (specify) _____		___ Entire Record

All records pertaining to drug or alcohol abuse records will not be released unless specifically authorized below. I understand tha records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part cannot be disclosed without my written consent unless otherwise provided for in the regulations.
___ Drug or Alcohol Abuse (Signature) _____ Date _____

For the purpose of: ___ Continued Health Care ___ Legal ___ Other _____
___ Insurance/Billing ___ Personal

This authorization shall remain in effect until the following date, event or condition _____
If no date, event or condition is specified, this authorization will expire in 6 months.

1. I understand I have the right to revoke this authorization at any time.
2. I understand that if I revoke this authorization I must do so in writing.
3. I understand a revocation will not apply to information that has already been released in response to this authorization.
4. I understand a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
6. I need not sign this authorization to assure treatment.
7. I understand that I may inspect or receive copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
8. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by the federal privacy regulations the information described above may be redisclosed and no longer be protected by these federal regulat
9. If I have any questions about the disclosure of my health information I can contact the Avera St. Luke's Privacy Officer at (605) 622-5284.

_____ _____
Signature of Patient or Legal Guardian Date of Signature

_____
Relation (if NOT the patient)

_____ _____
Signature of Witness Date of Signature

READ BACK POLICY

Policy: All orders for treatment shall be in writing. Any telephone or verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the responsible practitioner. **Verbal communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible.**

Verbal and Telephone Orders

1. Verbal or telephone orders may be accepted from the physician or physician's designated agent. (Physician will be used in the next steps).
2. The person accepting the order will write the order and read it back to the physician and the physician will confirm the order is correct. Orders are documented on the Outpatient Physician's Order sheet by the person receiving the order.
3. Signs/symptoms must be documented in the appropriate section of the Outpatient Physician's Order sheet. ******
4. **"Physician Signature" area**: VORB (verbal order read back) or TORB (telephone order read back), ordering physician's name, and if applicable, name of physician's agent communicating the order, and the name and title of the person receiving the verbal order must be documented.
5. **"Date Order Sent" area:** The date and time that the verbal/telephone order was received must be documented.
6. If the physician does not allow time to read back the order, the person accepting the order should document that on the Outpatient Physician Order sheet.
7. Additional information should be documented on the Outpatient Physician's Order sheet as appropriate (patient name, date of birth, etc).
8. All completed VORB or TORB Outpatient Orders sheets are sent to Health Information Management (HIM). HIM notifies physician of necessity to sign orders within 30 days. Failure to comply is addressed by the Medical Staff By-Laws Article V, Section 4.

****Patient procedure(s) will not be performed until all required information is documented.**

Registered nurses, registered pharmacists, licensed nutritionists, registered physical therapists, registered occupational therapists, registered radiologic technologists, registered laboratory technologists/technicians and registered respiratory therapists, certified respiratory therapy technicians, speech therapists and licensed practical nurses are authorized to accept verbal orders.

Facsimile Orders

Physician orders received via facsimile are acceptable. They must include the date, time and ordering physician's signature. The order is sent to Centralized Scheduling to be scheduled and scanned.

Completion/Sign-off of Department Orders

The person completing the physician order for their department should document the following information under the Physical Findings and/or Treatment section of the outpatient registration form (Health and Referral Profile, Section 1).

- Date/time test completed
- Each individual test that was completed.
- Name (at least 1st initial, last name), title

When a physician is contacted regarding an order or change in a patient's condition, information should be charted on the Health and Referral Profile, Section 1.

- **Outpatient Physician's Order form**: Individual test(s) may be marked off and initialed by the technologist as appropriate. When initials are used, record initials and signature in the Health and Referral Profile, Section 1.

- **Signing-off by Students**: Students must follow the guidelines for completion/sign-off of department orders. A technologist must co-sign all student sign-offs.

Patient Appointment Sheet

A sheet listing the patient's appointments should be included with the outpatient registration paperwork. After all tests are completed for the department, the technologist completing the procedure should checkmark and initial next to the completed procedure on the sheet. When appointments are scheduled for other departments the patient should be escorted or directed to the next appointment.

References: College of American Pathologists Laboratory General Checklist 7.31.2012; GEN.40935.