Tracie A'ano, Laboratory Supervisor

LABORATORY SERVICES

TONHC Specimen Collection Overview - 02.18.2020

AGENDA

- *Specimen Labeling*
- *Lab Forms Completion*
- *Critical Lab Reporting*

The truth of the story lies in the details.
- Paul Auster

SPECIMEN LABELING

Proper labeling of specimens

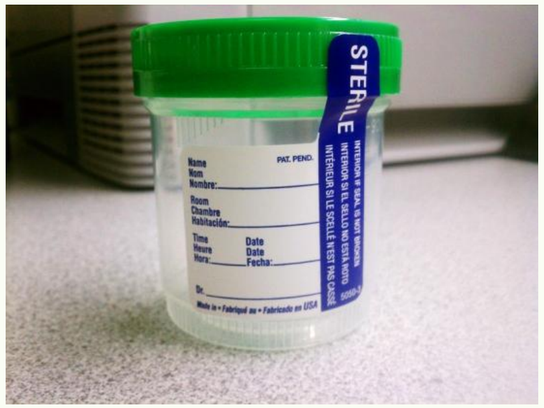
FULL
PATIENT NAME, DOB, CHART NUMBER

FULL
PATIENT NAME, DOB

FULL
PATIENT NAME, CHART NUMBER

- Per **NPSG 01.01.01**: labels must have at least 2 patient identifiers AND be labeled while patient is present
- Incorrectly labeled specimens will not be processed - please use caution
- Culture labels should include site of collection

Lab Specimens



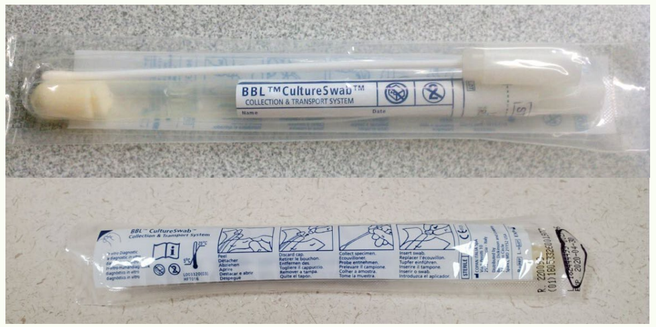
- Clean catch urine
- Protein reflex
- Pregnancy test
- Urine GC/Chlamydia
- Urine HCG

** Any color of sterile collection cup will work*

Common Swabs

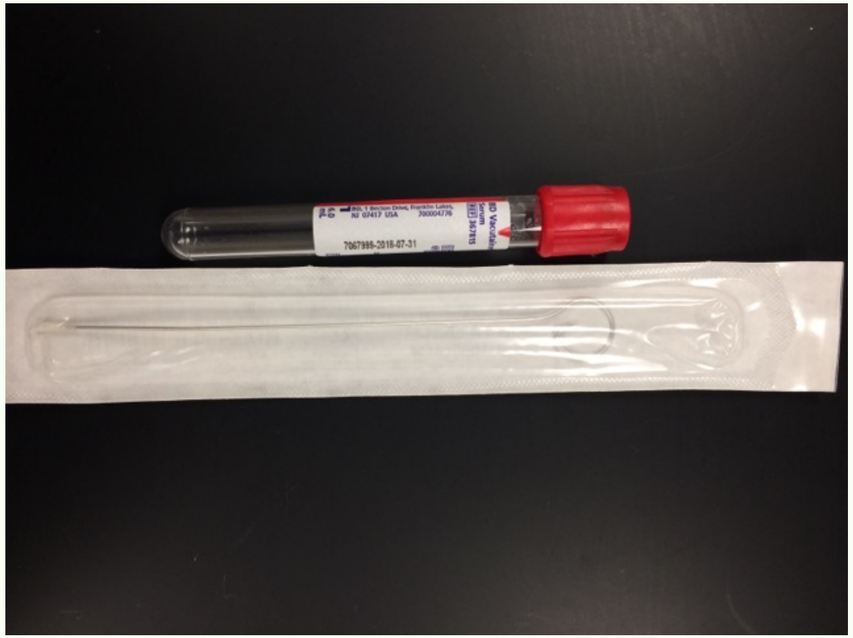
- Rapid Strep – Double swab

- Influenza Nasopharyngeal Swab (A or B)
  - Send 2 swabs in any combination
  - Please note these are FOAM tipped only



- Group Beta Strep
- Wound Culture
- Fecal Leukocytes

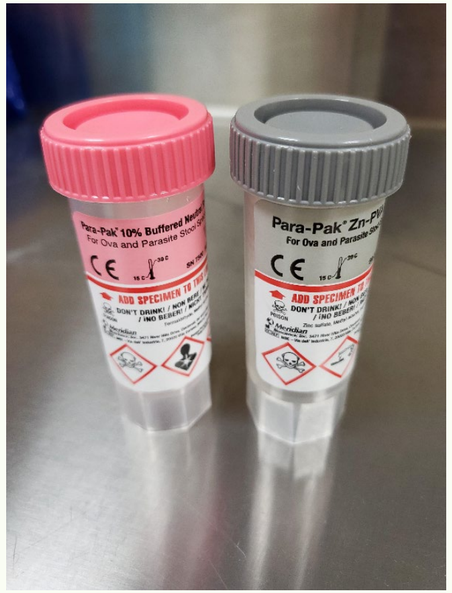
Viral testing



- RSV (items given by lab)
- RED TOP TUBE & WIRE SWAB

- Viral Media/HSV

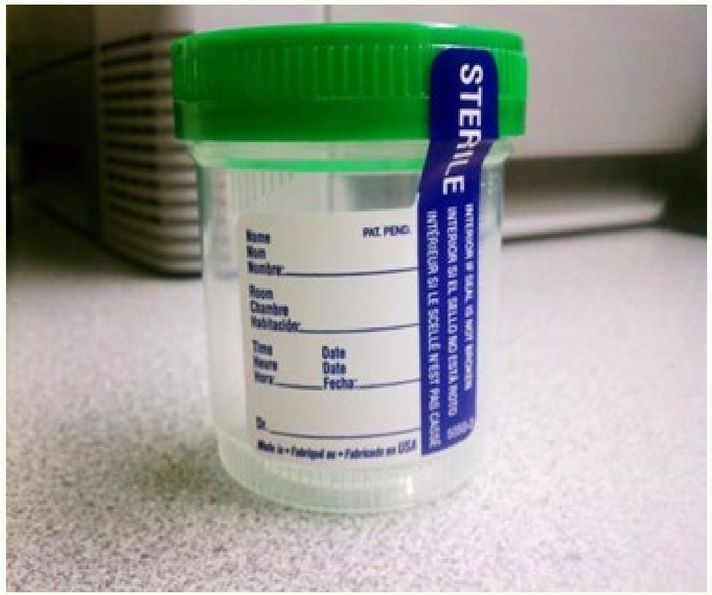
Stool Specimens



- Ova & Parasite Exam
- Giardia

- Stool culture

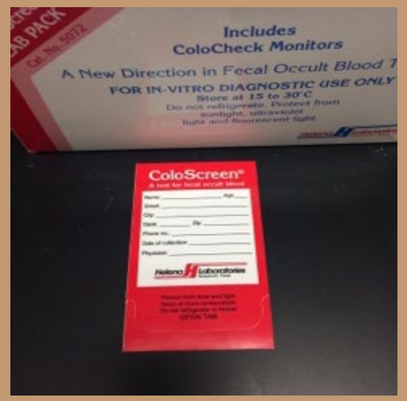
Additional Stool Tests



- Clostridium difficile (C. Diff)
- Helicobacter pylori (H. Pylori)

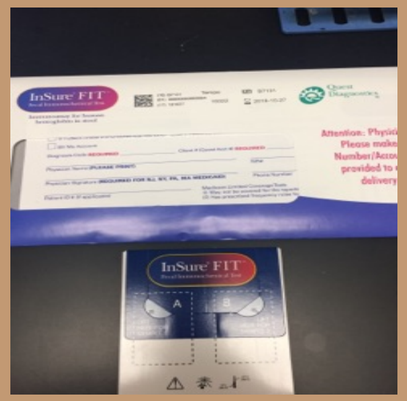
** Submit actual stool sample for testing*

Additional Stool Tests



Hemoccult

In-house test



Occult Blood-FIT

Send-out test

** Each test has its own unique order in CPRS. Order entry must match slide collected.*

Blue tube specifics

- BOTH tubes exist in the TONHC inventory
- Either tube can be used when a “BLUE TUBE” is indicated for a specimen
- Please fill to line indicated by black arrows.
- The tube with the lower fill line will also have a white ring on the top aspect

Blood Cultures

Adult specimen

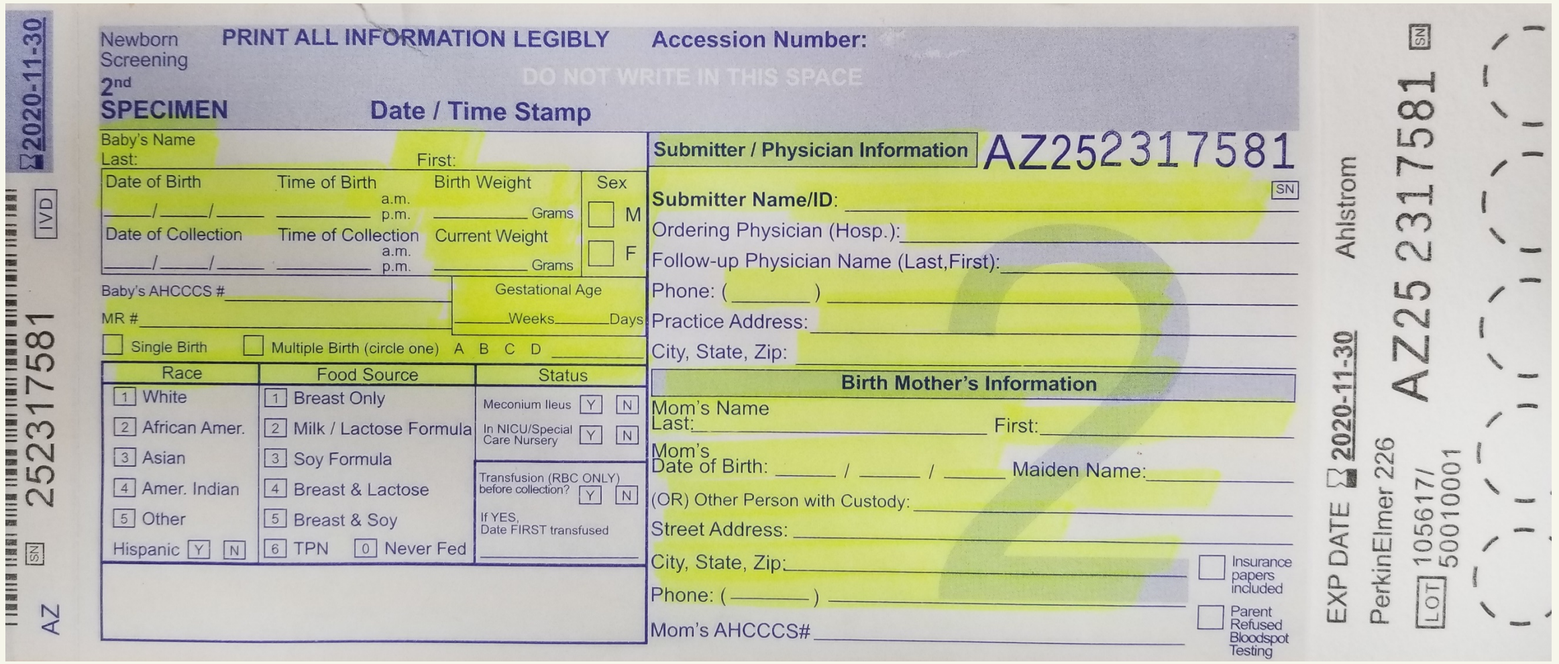
One pair of bottles per Blood Culture order if adult. One pink bottle for Pediatric.

Pediatric or younger

** Please note fill lines indicated by black marks*

LAB FORMS COMPLETION

Newborn Screening



Newborn Screening
2nd SPECIMEN

PRINT ALL INFORMATION LEGIBLY

Accession Number:

DO NOT WRITE IN THIS SPACE

Date / Time Stamp

2020-11-30 IVD

AZ 252317581 SN

Baby's Name
Last: First:

Date of Birth ____/____/____
Time of Birth ____ a.m. p.m.
Birth Weight ____ Grams
Sex M F

Date of Collection ____/____/____
Time of Collection ____ a.m. p.m.
Current Weight ____ Grams

Baby's AHCCCS # ____
MR # ____
Gestational Age ____Weeks____Days

Single Birth Multiple Birth (circle one) A B C D

Race	Food Source	Status
1 White	1 Breast Only	Meconium Ileus Y N
2 African Amer.	2 Milk / Lactose Formula	In NICU/Special Care Nursery Y N
3 Asian	3 Soy Formula	
4 Amer. Indian	4 Breast & Lactose	Transfusion (RBC ONLY) before collection? Y N
5 Other	5 Breast & Soy	If YES, Date FIRST transfused
Hispanic Y N	6 TPN 0 Never Fed	

Submitter / Physician Information AZ252317581 SN

Submitter Name/ID: ____
Ordering Physician (Hosp.): ____
Follow-up Physician Name (Last,First): ____
Phone: ( ) ____
Practice Address: ____
City, State, Zip: ____

Birth Mother's Information

Mom's Name
Last: ____ First: ____
Mom's Date of Birth: ____ / ____ / ____ Maiden Name: ____
(OR) Other Person with Custody: ____
Street Address: ____
City, State, Zip: ____
Phone: ( ) ____
Mom's AHCCCS# ____

Insurance papers included
Parent Refused Bloodspot Testing

EXP DATE 2020-11-30
PerkinElmer 226
LOT 105617/ 50010001

Ahlstrom
AZ25 2317581 SN

SF-518

518-123 NSN 7540-00-634-4158

MEDICAL RECORD — BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I - REQUISITION

COMPONENT REQUESTED *(Check one)*
- ☐ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- ☐ TYPE AND SCREEN
- ☐ CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)*

_____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED

TIME VERIFIED

SECTION II - PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH	PREVIOUS RECORD CHECK: ☐ RECORD ☐ NO RECORD / SIGNATURE OR PERSON PERFORMING TEST
DONOR / ABO / Rh	RECIPIENT / ABO / Rh	☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED		DATE
		REMARKS:		

SECTION III - RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN | TIME/DATE COMPLETED/INTERRUPTED

REACTION ☐ NONE ☐ SUSPECTED | TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected – IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
- ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
- ☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- ☐ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION – USE EMBOSSER (For typed or written entries give: Name–Last, first, middle; grade; rank; rate; hospital or medical facility) | SEX | WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Blood Consent

Tohono O'odham Nation Health Care Sells Hospital
Transfusion of Blood/Blood Products
Consent Form

1. I give my permission to receive a transfusion of blood/blood product(s)
_____ as my doctor and his/her associates recommend.
(Specify type of product)

2. The reason for the transfusion has been explained to me as
_____.
(Layman terms)
Alternatives to transfusions may not always work to improve my condition. I also understand that even when much care is taken, transfusion can cause problems such as:

   a.) Allergic Reactions
   b.) Hepatitis
   c.) Acquired Immune Deficiency Syndrome (AIDS)
   d.) Develop allergies that will make future transfusions more difficult.
   e.) Possible exposure to other diseases.

3. The above has been explained to me by my physician _____
(Print physician name)
and all my questions have been answered.

4. I have been informed of alternatives to receiving a blood transfusion/blood products.

5. I accept on behalf of myself (the patient) the risks associated with a transfusion as described above.

_____ @_____ _____
Patient Signature — Time — Date

_____ @_____ _____
Patient Representative/Interpreter (if patient is unable to sign) — Time — Date

_____ @_____ _____
Physician Signature — Time — Date

_____ @_____ _____
Witness Signature — Time — Date

Name:	
DOB:	
Chart#:	

TONHC Pt Consent
Updated 1.2020 tma

Emergency Consent

Tohono O'odham Nation Health Care
Sells Hospital
P.O. Box 548 Highway 86
Sells, Arizona 85634

********* **UNCROSSMATCHED**********

EMERGENCY RELEASE OF BLOOD COMPONENTS
WITHOUT COMPLETION OF BLOOD BANK TESTS

I, the undersigned, have deemed the clinical situation was sufficiently emergent to require release of uncrossmatched blood components. I affirm the benefit of using uncrossmatched blood outweighs the risk. I assume all responsibility for ordering blood (packed red blood cells) to be given to the patient, named below, without completion of blood bank compatibility testing. I further understand that the blood bank laboratory technical staff will perform compatibility testing as soon as possible and that any incompatible test result will be reported to me immediately.

In my professional medical judgment, this patient's life will be in jeopardy without an emergency transfusion.

Please supply _____ units of: ☐ Group O, Rh negative red blood cells
☐ ABO type specific red blood cells
☐ Other, specify: _____

M.D._____ or, R.N.: _____

For M.D.: _____ **Date**: _____ **Time**: _____

Lab Use Only: Tech Initials ____

PATIENT IDENTIFICATION - USE EMBOSSER

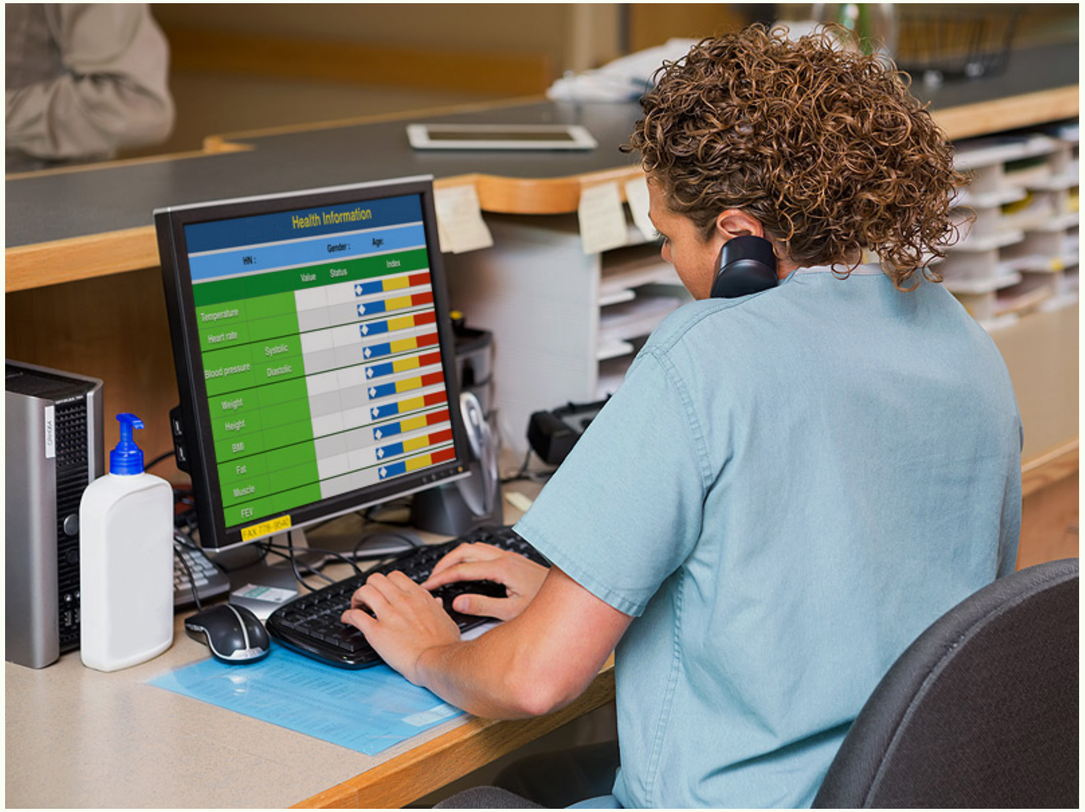
Document or adhere BUI sticker(s) of units here.

Medical Records
TONHC – 1BB
Implemented 4/2017

CRITICAL LAB REPORTING

Critical Lab Reporting

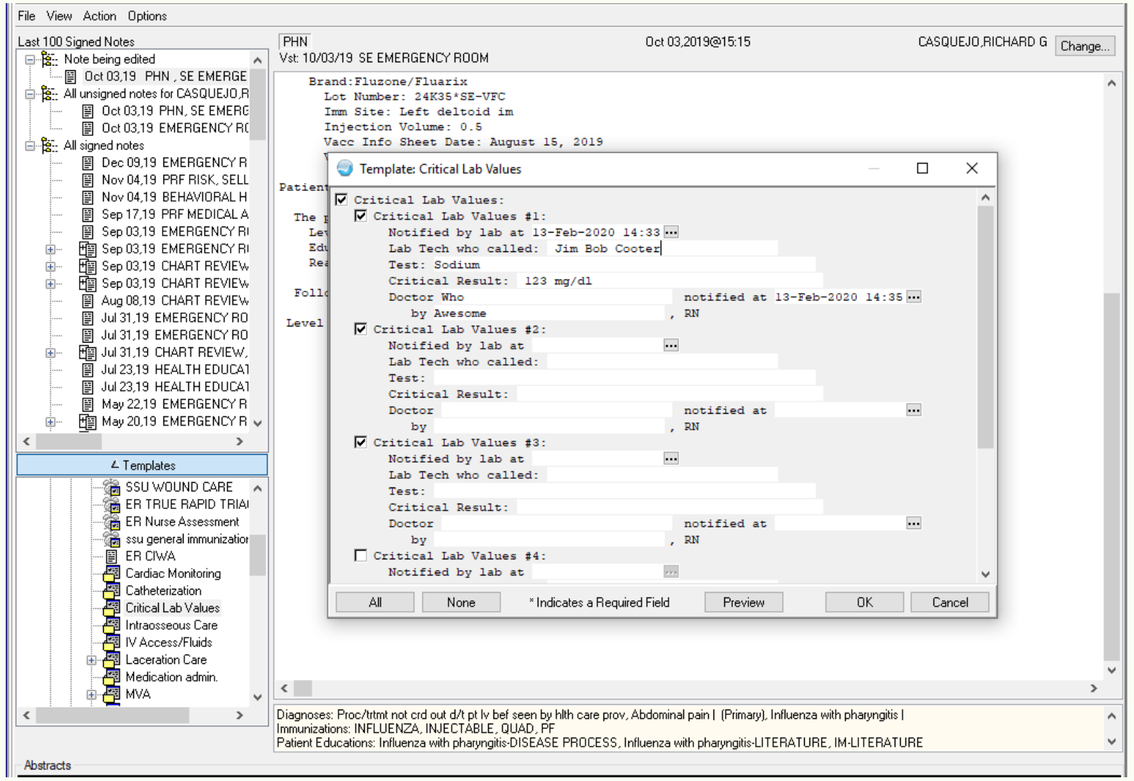
- NPSG.02.03.01 requires reporting of critical diagnostic test results on a timely basis
- Per TONHC policy it is mandatory to complete this within 15 minutes.



** This call can only be taken by a Registered Nurse or Provider*

Recording Critical Labs

- Activate each section by clicking “Critical Lab Values #(X)”
- Complete one section for *each* lab value



** This template must be charted in the Nurses note*

Attention to detail can't be (and never is) added later.

- Marco Arment

QUESTIONS?

CONTACT

TONHC Sells Laboratory Services

520-383-7233