Appendix A

BD Vacutainer® Venous Blood Collection Tube Guide

For the full array of BD Vacutainer® Blood Collection Tubes, visit www.bd.com.
Many are available in a variety of sizes and draw volumes. Refer to our website for full descriptions.

BD Vacutainer® Tubes with BD Hemogard™ Closure	BD Vacutainer® Tubes with Conventional Stopper	Additive	Inversions at Blood Collection*	Laboratory use	Laboratory notes
 Red	 Red	• Silicone coated (glass) • Clot activator - Silicone coated (plastic)	0 5	For chemistry determinations in serum. May be used for routine blood donor screening and diagnostic testing of serum for infectious disease.** Tube inversions ensure mixing of clot activator with blood. Blood clotting time: 60 minutes.	
 Gold	 Red/ Gray	• Clot activator and gel for serum separation	5	For chemistry determinations in serum. May be used for routine blood donor screening and diagnostic testing of serum for infectious disease.** Tube inversions ensure mixing of clot activator with blood. Blood clotting time: 30 minutes.	
 Orange		• Thrombin-based clot activator with gel for serum separation	5 to 6	For stat chemistry determinations in serum. Tube inversions ensure mixing of clot activator with blood. Blood clotting time: 5 minutes.	
 Light Green		• Lithium heparin and gel for plasma separation	8	For chemistry determinations in plasma. Tube inversions ensure mixing of anticoagulant (heparin) with blood to prevent clotting.	
 Green  Translucent Green	 Green	• Sodium heparin • Lithium heparin	8 8	For chemistry determinations in plasma. Tube inversions ensure mixing of anticoagulant (heparin) with blood to prevent clotting.	
 Lavender  Translucent Lavender	 Lavender	• Liquid K_3EDTA (glass) • Spray-coated K_2EDTA (plastic)	8 8	K_2EDTA and K_3EDTA for whole blood hematology determinations. K_2EDTA may be used for routine immunohematology testing.*** Tube inversions ensure mixing of anticoagulant (EDTA) with blood to prevent clotting.	
 Pink		• Spray-coated K_2EDTA (plastic)	8	For whole blood hematology determinations. May be used for routine immunohematology testing.*** Designed with special cross-match label for patient information required by the AABB. Tube inversions ensures mixing of anticoagulant (EDTA) with blood to prevent clotting.	
 White		• K_2EDTA and gel for plasma separation	8	For use in molecular diagnostic test methods (such as, but not limited to, polymerase chain reaction [PCR] and/or branched DNA [bDNA] amplification techniques.) Tube inversions ensure mixing of anticoagulant (EDTA) with blood to prevent clotting.	
 Light Blue  Clear		Buffered sodium citrate 0.109 M (3.2%) plastic	3-4	For coagulation determinations. Tube inversions ensure mixing of anticoagulant (citrate) to prevent clotting.	
 Gray	 Gray	• Potassium oxalate/ sodium fluoride • Sodium fluoride/Na_2EDTA • Sodium fluoride (serum tube)	8 8 8	For glucose determinations. Oxalate and EDTA are anticoagulants and NaF is an antiglycolytic agent. Tube inversions ensure proper mixing of additive with blood.	
 Royal Blue		• Clot activator (plastic) • K_2EDTA (plastic)	8 8	For trace-element, toxicology, and nutritional-chemistry determinations in serum or plasma. Special stopper formulation provides low levels of trace elements (see package insert). Tube inversions ensure proper mixing of additive with blood.	
	 Yellow	• Sodium polyanethol sulfonate (SPS)	8	SPS for blood culture specimen collections in microbiology.	
		• Acid citrate dextrose additives (ACD): – **Solution A:** 22.0 g/L trisodium citrate, 8.0 g/L citric acid, 24.5 g/L dextrose – **Solution B:** 13.2 g/L trisodium citrate, 4.8 g/L citric acid, 14.7 g/L dextrose	 8 8	ACD for use in blood bank studies, and paternity testing. Tube inversions ensure mixing of anticoagulant with blood to prevent clotting.	
 Clear	 Red/ Light Gray	• No additive (plastic)	0	For use as a discard tube or secondary specimen tube.	

BD Vacutainer® Tubes with a translucent cap are designed to draw less blood as indicated on the tube label. Small-volume, partial-draw tubes fill more slowly than full-draw tubes due to a lower vacuum.

For additional information refer to the IFU at eifu.bd.com.

BD Life Sciences,
7 Loveton Circle, Sparks, MD
21152-0999, U.S.

BD Global Technical Services: 1.800.638.8663, Option 3
BD Customer Service: 1-844-823-5433, 1-844-8-BD-LIFE
www.bd.com

* Invert gently, do not shake.
** The performance characteristics of these tubes have not been established for infectious disease testing in general; therefore, users must validate the use of these tubes for their specific assay-instrument/reagent system combinations and specimen storage conditions.
*** The performance characteristics of these tubes have not been established for immunohematology testing in general; therefore, users must validate the use of these tubes for their specific assay-instrument/reagent system combinations and specimen storage conditions.

Appendix B

CONWAY REGIONAL LABORATORY SERVICES

Laboratory Downtime Requistion

		Order Date:
		Order Time:
		Priority (circle one): STAT URGENT ROUTINE TIMED
For tests ordered "**Routine**" or "**Timed**", please indicate date and time to be collected.	Date:	Time:
Name (Last, First):		
Date of Birth:		
Medical Record Number:		
Ordering Location:	Room Number:	
Ordering Provider:		

Test(s) Requested:	Specimen Information		
	Phlebotomist:		
	Collected:	Date	Time
	Received:	Date	Time

9/1/2023

Appendix C

CONWAY REGIONAL LABORATORY SERVICES
2302 College, Ave Conway, AR 72034
Phone: 501-513-5752 Fax: 501-513-5535

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI

DATE OF BIRTH | AGE | SEX

ADDRESS

CITY | STATE | ZIP | PHONE NUMBER

REFERRING INSTITUTION NAME AND ADDRESS

REFERRING PROVIDER

SPECIMEN

COLLECTED BY:

DATE: | **TIME:**

SPECIMEN TYPE:

DIAGNOSIS

Do any of the tests ordered require an ABN? _____

BILLING INFORMATION

Please include a copy of the patient's insurance card

☐ CLIENT BILL ☐ INSURANCE ☐ MEDICARE ☐ MEDICAID

MEDICARE NUMBER

MEDICAID NUMBER | STATE | PCP

GROUP NUMBER | MEMBER NUMBER

INSURANCE NAME

INSURANCE ADDRESS | CITY | STATE | ZIP

GROUP NUMBER | MEMBER NUMBER

PRIMARY SUBSCRIBER | RELATIONSHIP TO INSURED

☐ DEPENDANT ☐ SPOUSE ☐ SELF

When ordering clinical laboratory tests, the provider is required to make an independent medical necessity decision with regard to each test the laboratory will bill. Specific ICD-10 codes are required in order to be approved for payment. The ICD-10(s) listed by the provider must be supported in the patient's medical record. Medicare and other insurers may not pay for screening tests. If a specific test is not supported by documentation in the medical record or is clearly for screening purposes, the test must be designated as a screening test and must be accompanied by a signed ABN.

CHEMISTRY

_____	Albumin	ALB
_____	Alkaline Phos	ALKPH
_____	ALT	ALT
_____	Amylase	AMY
_____	AST	AST
_____	Bilirubin, Direct	BILIDIRECT
_____	Bilirubin, Total	BILITOTAL
_____	Pro-BNP	BNP
_____	BUN	BUN
_____	CA 125	CA125
_____	CA 19.9	CA19 9
_____	Calcium	CA
_____	Carbon Dioxide	CO2
_____	CEA	CEA
_____	Chloride	CL
_____	Cholesterol	CHOL
_____	CK	CK
_____	hsCRP	CRPHS
_____	Creatinine	CREA OUTREACH
_____	Digoxin	DIGOX
_____	Ferritin	FER
_____	Folic Acid	FOLBA
_____	Free T3	T3
_____	Free T4	T4
_____	GGT	GGT
_____	Glucose	GLU
_____	HDL Cholesterol	HDLD
_____	Hgb A1C	A1C
_____	Ionized Calcium	ICA
_____	Iron	FE
_____	LDH	LDH
_____	Lipase	LIPA
_____	Lithium	LI

CHEMISTRY

_____	Magnesium	MG
_____	Microalbumin	UR MICROALB
_____	Phosphorus	PHOS
_____	Potassium	K
_____	Prealbumin	PREALB
_____	PSA (Diagnostic)	PSA
_____	PSA (Screen)	PSASCREEN
_____	PTH Intact	IPTH
_____	Quantitative hCG	HCGQ
_____	Sodium	NA
_____	Total T4	T4
_____	Testosterone, Total	TEST
_____	Total Protein	TP
_____	Total T3	T3
_____	Transferrin	TRF
_____	Triglyceride	TRIG
_____	Troponin	TNT
_____	TSH	TSH
_____	Uric Acid	URIC
_____	Valproic Acid	VAL
_____	Vancomycin	VANR
_____	Vit D 25 Hydroxy	VITD
_____	Vitamin B-12	B12

CHEMISTRY PANELS

_____	Basic Panel	BMP.OUTREACH
_____	Comp Panel	CMPOUTREACH
_____	Electrolytes	LYT
_____	Hepatic Panel	LIVER
_____	Hepatitis Panel	HEP PROF
_____	Lipid Panel	LIPIDOUTREACH
_____	Renal Panel	RENAL
_____	TIBC Profile	FETIBC

HEMATOLOGY

_____	CBC	CBC
_____	CBC with Diff	CBCD
_____	Hemoglobin	HGB
_____	Hematocrit	HCT
_____	ESR	ESR
_____	Platelet	PLT
_____	Retic	RETIC
_____	Path Slide Review	PATH SLIDE

MOLECULAR

_____	Strep A	STRPA
_____	C.Diff*	CDIFFM
_____	BioFire GI Panel	GIPANEL
_____	BioFire Resp Panel	RVP
_____	Covid	SARSCOV2F
_____	Flu/RSV/Covid	FRVP
_____	Chlamydia/Gonorrh	CTNG
_____	Trichomonas	TV

MICROBIOLOGY

_____ Culture, Aerobic*

Source: _____

_____ Culture, Anaerobic*

Source: _____

_____	Culture, Fungal*	FUNGAL
_____	Culture, Stool*	CULTSTOUTREACH
_____	Culture, Urine*	CULTU
_____	Culture, Blood*	CULTBLD
_____	Ova & Parasite*	OP

SEROLOGY

_____	HIV Ab/Ag*	HIV DUO
_____	H. Pylori, Serum	HPYLORI
_____	H. Pylori, Stool	HPYLORI AG
_____	Pregnancy Serum	PREGS
_____	Pregnancy Urine	PREGU
_____	RA Factor	RF
_____	Treponemal Ab*	TPPA

URINALYSIS

_____	UA w/ Microscopic	UAMICRO
_____	Urine Protein	UTPC
_____	Urine Creatinine	UCREA
_____	24H Creat Clearance	CRCL24
	Requires a serum specimen	
_____	Urine Drug Screen	DS10
	For medical purposes only	
_____	Prot/Creat Ratio	PROTCREAT

COAGULATION

_____	PT/INR	PT INR
_____	APTT	PTT
_____	D-DIMER	DDIMER
_____	Fibrinogen	FIB

MISCELLANEOUS

See reverse for panel components and information regarding reflex and confirmation testing.

Ordering Provider Signature

Order Date

PANEL COMPONENTS

COMP PANEL
- Albumin
- Alkaline Phos
- ALT
- AST
- BUN
- Bili, Total
- Calcium
- Chloride
- Carbon Dioxide
- Creatinine
- Glucose
- Potassium
- Sodium
- Total Protein

BASIC PANEL
- BUN
- Calcium
- Chloride
- Carbon Dioxide
- Creatinine
- Glucose
- Potassium
- Sodium

LIPID PANEL
- Cholesterol
- Triglyceride
- LDL
- HDL

ELECTROLYTES
- Potassium
- Sodium
- Chloride

HEPATITIS PANEL
- Hep A Ab
- Heb B core Ab
- Heb B surface Ab
- Heb B Surface Ag
- Hep C Ab

TIBC PANEL
- Iron
- TIBC
- UIBC
- Iron Saturation

HEPATIC PANEL
- Albumin
- Alkaline Phos
- ALT
- AST
- Bili, Total

RENAL PANEL
- BUN
- Creatinine
- Sodium
- Potassium
- Calcium
- Albumin
- Phosphorus

Tests noted with an asterisk may include reflex or confirmation testing. Reflexed tests will incur an additional charge. If reflex testing is not desired, please note when ordering tests.

Microbiology Cultures: ID and sensitivity will be ordered by reflex if a microbiology culture meets positive criteria.
HIV Ab/Ag: Positive HIV screen will be sent to our reference lab for confirmation
Molecular C. diff: A C.diff toxin will be ordered by reflex on all molecular C.diff positive tests
Treponemal Ab: Positive tests will reflex to RPR for confirmation

Conway Regional Patient Portal

The Conway Regional Patient Portal allows you to be actively involved in your health care by providing a confidential, web-based tool and mobile app for accessing information regarding your appointments and health records with Conway Regional.

Download the mobile app:
MEDITECH MHealth

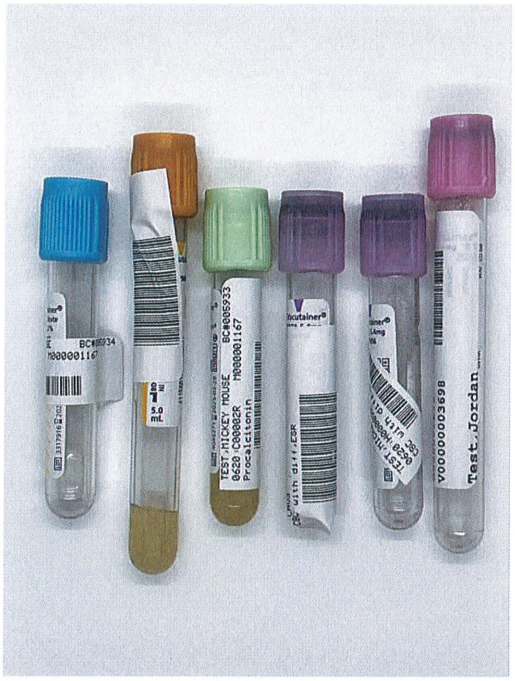
Download on the App Store | GET IT ON Google Play

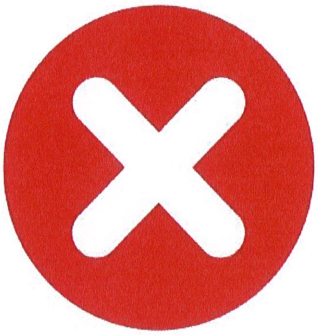
Scan the QR code or visit crhs.healthcare/patientportallogin to create your profile

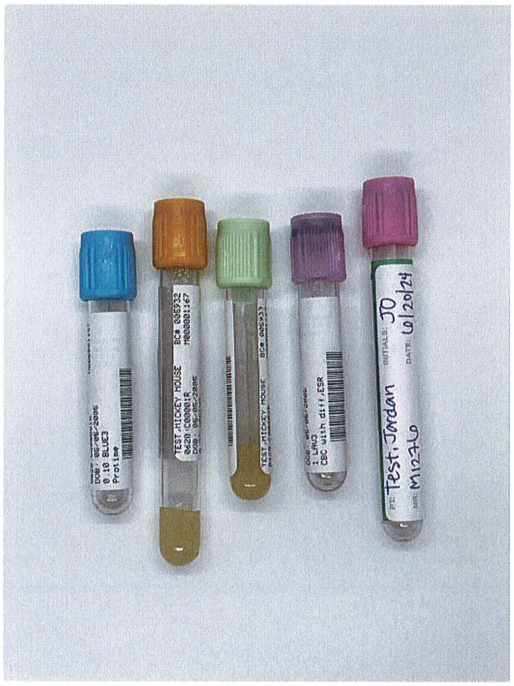
Appendix D

Specimen Label Placement

Labels should be placed lengthwise on the specimen tube covering the manufacturer's white label without obscuring the contents of the tube.







CONWAY REGIONAL
LABORATORY SERVICES

Appendix E

CONWAY REGIONAL
LABORATORY SERVICES

Critical Value Table		
Test	**Critical low**	**Critical High**
Acetaminophen		>30 ug/ml
Alcohol ETOH		>300 mg/dl
Bilirubin, Neonatal		>15.0 mg/dl
Carbamazepine		>20 ug/ml
Calcium	<6.6 mg/dl	>13.0 mg/dl
Calcium, Ionized	<0.78 mmol/l	>1.57 mmol/l
Chloride	<75 mmol/l	>125 mmol/l
CO2	<10 mmol/l	>40 mmol/l
CSF, Protein		>100 gm/dl
CSF, WBC		>15.0/ul
Digoxin		>2.5 ng/ml
Fibrinogen	<88 mg/dl	
Gentamicin, Trough		>2.0 ug/ml
Gentamicin, Peak		>12 ug/ml
Glucose	<45 mg/dl	>450 mg/dl
Glucose, Neonatal	<43 mg/dl	>200 mg/dl
Hemoglobin	<7.0 g/dl	>20 g/dl
Hemoglobin, Neonatal	<12.0 g/dl	
Hematocrit	<20.0 %	>60.0 %
Hematocrit, Neonatal	<40 %	>64 %
Lactic Acid, >16 years		>3.0 mmol/l
Lithium		>1.5 mmol/l
Magnesium	<1.0 mg/dl	>4.9 mg/dl
Phenobabital		>60 ug/ml
Phenytoin		>40 ug/ml
Phosphorus	<1.2 mg/dl	>8.9 mg/dl
Platelets	<20 x 1000/ul	>1000 x 1000/ul
Potassium, Neonatal	<3.0 mmol/l	>7.8 mmol/l
Potassium, 1-10 years	<3.0 mmol/l	>6.4 mmol/l
Potassium, >10 years	<3.0 mmol/l	>6.2 mmol/l
Protime/INR		>5.0 INR
PTT		>60 seconds
Sodium	<120 mmol/l	>160 mmol/l
Salicylate		>30 mg/dl
Troponin T		> 50 ng/l
Valproic Acid		> 200 ug/ml
Vancomycin, Trough		> 25 ug/ml
WBC	<1.5 x 1000/ul	>30.0 x 1000/ul
Other Critical Results		
Microbiology		
Gram Stain	Any positive finding on CSF or Blood Culture	
CSF Specimen	Any positive smear or culture	
Blood Culture	Any positive smear or culture	
Malarial Parasites	Positive result	
RPR, Neonatal	Reactive RPR result	
Hematology		
Sickle Cell	Presence of drepanocytes with no previous history	
CBC Differiental	Any cell younger than a myelocyte, confirmed by pathologist	
Urinalysis		
Urinalysis	Presence of pathologic crystals	
Urinalysis, Neonatal	Positive glucose and/or ketones	
Blood Bank		
Antibody Screen	Any positive result	
DAT	Any positive result on cord blood	

6/2024

Appendix F

CONWAY REGIONAL
HEALTH SYSTEM

RELEASE & ADMINISTRATION OF BLOOD TRANSFUSIONS UNDER EMERGENCY CONDITIONS

In an emergency, the risk of infusing un-crossmatched or incompletely crossmatched blood must be weighed against the hazard of waiting for a proper compatibility test. The physician must accept the responsibility for any complications exhibited in the patient caused by an antigen-anti body reaction that would have been detected by compatibility testing. By order of the Administrator, and according to regulations of the American Association of Blood Banks, the physician must indicate his/her acceptance of this potential risk in writing. Such a release does not absolve the blood bank from its responsibility to issue properly grouped or labeled blood.

The undersigned, lawfully authorized to practice the profession of medicine in the State of Arkansas, does hereby certify as follows:

"The patient named above is under my professional care due to illness or accident, and has been carefully examined said-patient. It is my firm professional opinion that, because of said patient's condition, an emergency involving the patient's safety exists.

Because of this emergency, I request that a blood transfusion be administered to the above named patient promptly, and I accept the responsibility of having this blood administered before all crossmatching procedures prescribed by Laboratory Policy & Procedure have been completed, as indicated below.

Please check the appropriate line:

☐ **GROUP O RBCS, UNCROSSMATCHED:**
Group O positive RBCs will be provided for male patients and female patients without childbearing potential.
Group O negative RBCs will be provided for pediatric patients and female patients with childbearing potential.
TIME AVAILABLE: upon receipt of this signed release form

☐ **IMMEDIATE SPIN CROSSMATCH:** Patient's received specimen is typed, type specific blood is tested at room temperature for compatibility. Antibody Screen testing is incomplete, patient may still exhibit unsuspected antibodies to the blood component transfused.
TIME AVAILABLE: Approximately 30 minutes from receipt of patient's specimen

☐ **SUSPECTED ANTIBODY:** Antibody testing shows the presence of an unsuspected antibody. Compatibility testing is incomplete and/or no compatible units are available at this time.
TIME AVAILABLE: 1 hour after receipt of patient's specimen.

Physician Signature	Date	Time
Witness Signature	Date	Time

Appendix G

CONWAY REGIONAL HEALTH SYSTEM

BLOOD TRANSFUSION REACTION REPORT

CLINICAL REPORT (NURSING SERVICE COMPLETES)

Date of this report: _____

Type of component: ☐ RBC ☐ FFP ☐ PLT ☐ Cryo

☐ Laboratory Notified Time: _____

☐ Physician Notified Time: _____

RN initiating report: _____

Donor unit number: _____

Time transfusion began: _____

Time transfusion stopped: _____

Amount infused: _____

Fluids and/or meds given during transfusion at same IV site or port as blood _____

☐ Clerical check performed. By: _____

☐ Blood container and "set" sent to laboratory

☐ First urine voided after reaction sent to laboratory

CHECK SYMPTOMS

☐ 2° F rise in temperature	☐ Flushing
☐ Shock	☐ Rash
☐ Hypotension	☐ Hives/Itching
☐ Dyspnea	☐ Oliguria
☐ Chest Pain	☐ Anuria
☐ Cyanosis	☐ Hemoglobinuria
☐ Hypertension	☐ Generalized bleeding
☐ Nausea	☐ Pain at the infusion site
☐ Back pain	

Patient's Vital Signs	Temp.	Pulse	Resp.	B/P
Pre-transfusion				
Post-transfusion				

LABORATORY REPORT

Clerical check performed: ☐ No error ☐ Error (specify under comments)

☐ Post-transfusion specimen drawn Time: _____

Urine specimen: Color _____ Hgb: _____

Donor unit number: _____

Blood container returned: _____ (volume mL)

Gram stain results on donor unit: _____

Culture results on donor unit: _____

☐ Lab notified

Date: _____

Time: _____

Tech: _____

PART I

	Anti-Sera				Cells			Du			Hemolysis		Icterus	
	A	B	D	Cont	AI	A2	B	Du	Cont	Direct Coombs	Yes	No	Yes	No
Repeat Testing														
Pre-Transfusion														
Post-Transfusion														
Donor #														
Donor #														

*Notify clinical pathologist of above results - Called: _____, MD @ _____ Tech: _____

•Notify physician/nurse of pathology report - (1) OK to continue to transfuse patient, or (2) Not OK to continue to transfuse and continue with Part II of investigation. Notified _____ @ _____ by _____

CONWAY REGIONAL HEALTH SYSTEM

BLOOD TRANSFUSION REACTION REPORT

PART II

Antibody Screen

Pre-Transfusion						Post-Transfusion					
Cell	RT	37°C	AHG	Sample Date	Tech	Cell	RT	37°C	AHG	Sample Date	Tech
I						I					
II						II					
Cont.						Cont.					

Compatibility Testing - Include Units Transfused Within 24 Hours Prior to Reactions

Pre-Transfusion with				Post-Transfusion with			
Donor Unit #	RT	37°C	AHG	Donor Unit #	RT	37°C	AHG

Technical Comments:

Technologist: _____ Date _____ Time _____

Pathologist's Comments:

Pathologist: _____ Date _____ Time _____

Appendix H

CONWAY REGIONAL
LABORATORY SERVICES

Stool Specimen Collection Instructions for Patients

Your provider has ordered a lab test to be performed on a stool sample. We want to make the process as simple as possible for you. Please follow the collection instructions below. If you have questions, please contact your physician.

Collection Materials:	Instructions for 15 ml Orange/Purple top media:
• Orange top and/or purple top container(s) • Toilet hat • Gloves • Plain stool specimen container(s)* • Wooden tongue depressor* • Small orange top Carey-Blair tube* • Sterile swab* • Biohazard bag to deliver specimens • Copy of your lab order *Provided only if indicated.	• Print your name, date of birth, and the date and time of collection on each sample container. • Place the toilet hat under the toilet seat and collect the stool, making sure not to urinate on the stool specimen • Wearing gloves and using the plastic scoop inside the container lid, collect a marble sized portion of stool and place it into the container • **Fill ONLY to the red line, please do not overfill.** • Tighten the cap of the container so the specimen does not leak, invert container 4-5 times to mix • Dispose of the toilet hat and gloves in your regular trash • After removing gloves, wash your hands thoroughly with soap and water • Place the sample container into the bag • Store specimen at room temperature and deliver to the clinic or lab within 24 hours

Specimen Requirements (check all that apply):

- ❑ **GI Panel – Enteric Pathogen Transport Media (Orange top container)**
- ❑ **GI Panel (small sample volume) – Using a sterile swab, transfer specimen to Carey-Blair Media (Small Orange top tube)**
- ❑ **Stool Culture – Plain Sterile container and/or Enteric Pathogen Transport Media (Orange top container)**
- ❑ **Ova & Parasite – UNIFIX (Purple top container)**
- ❑ **Send Out Tests – Plain Sterile Container, bring to lab ASAP after collecting**

**** Specimens received in a diaper will be rejected***

Appendix I

CONWAY REGIONAL
LABORATORY SERVICES

Instructions for 24 Hour Urine Collection

Prepare the 24-hour collection container:

1. Your provider will supply you with a 24-hour urine collection container. Please label the container with your first and last name and date of birth.
2. Please note that specimens received unlabeled will not be processed and a recollection will be necessary.

Start of collection:

1. It is important to start the collection with an empty bladder. To do so:
    a. On rising in the morning, urinate into the toilet. Do not save this urine.
    b. At this time, please note the start date and time in the section at the bottom of this page.

24-Hour collection period:

1. Save all urine for the next 24-hours (24-hours from the start time noted below). A urine cup or hat may be used to collect the urine. The urine collected should be promptly poured into the collection container.
2. The 24-hour urine collection container must always be stored upright and refrigerated or on ice.

End of collection:

1. Urinate (if possible) at the end of the 24-hour period and pour into the container. At this time note the end date and time in the section at the bottom of this page.

Deliver the specimen:

1. Return this form and the container to your provider or the Conway Regional Medical Center Laboratory at 2302 College Avenue, Conway, Arkansas.

Patient Name:	**Date of Birth:**
Start Date:	**Start Time:**
End Date:	**End Time:**

Note: A blood sample may be required with some 24-hour urine collections. Please check with your provider or the laboratory to ensure all required samples have been collected.

March 1, 2024