BD Leucocount Assay - Test Request Form

Center Information:

Requested By: Date	EC	Sample ID	Sample Type	Leukocyte Reduction / Apheresis Start: Date	Time	Unit Volume	Lab Use Only	
							Test < 48 hours?	Comments (Optional)
__ /__ /__	_____		☐ RBC ☐ WB ☐ PLT	__ /__ /__	__:__	______ mL	☐ OK ☐ Not OK EC: ________	
__ /__ /__	_____		☐ RBC ☐ WB ☐ PLT	__ /__ /__	__:__	______ mL	☐ OK ☐ Not OK EC: ________	
__ /__ /__	_____		☐ RBC ☐ WB ☐ PLT	__ /__ /__	__:__	______ mL	☐ OK ☐ Not OK EC: ________	
__ /__ /__	_____		☐ RBC ☐ WB ☐ PLT	__ /__ /__	__:__	______ mL	☐ OK ☐ Not OK EC: ________	
__ /__ /__	_____		☐ RBC ☐ WB ☐ PLT	__ /__ /__	__:__	______ mL	☐ OK ☐ Not OK EC: ________	
__ /__ /__	_____		☐ RBC ☐ WB ☐ PLT	__ /__ /__	__:__	______ mL	☐ OK ☐ Not OK EC: ________	

Fax Completed Form to (303) 363-2479

Review By ______________________________ Review Date __________________________