



University of Utah Medical Center
Department of Obstetrics & Gynecology
Branch Perinatal Laboratory

30 North 1900 East
 Medical Research & Education Building, Room 320
 Salt Lake City, Utah 84132

D.Ware Branch, M.D. (Director)
 Huixia Yu (Sr. Lab Specialist) (801) 585-5189
 Kathy Peterson (Administrator) (801) 581-2558
Main Lab # (801) 581-6196
Main Fax # (801) 581-8626
CAP# 22089-07 | **CLIA#** 46D0678022

<input checked="" type="checkbox"/>	TEST NAME	CPT CODE	PRICE	SAMPLE PROCESSING INFORMATION
<input type="checkbox"/>	Lupus Anticoagulant Reflexive Panel (PT, PTT, DRVVT)	85610 85730 85613	\$38.00	Collect blood in blue top tube (Na citrate); centrifuge to yield platelet-poor plasma; send 2-4 mL of plasma in plastic cryovial or shipping tube; refrigerate or freeze
*	Reflex PTT-D 1:1 Mix	85732	\$20.62	* Note: If PTT and DRVVT are normal, then no further testing is performed. If PTT is abnormal, Thrombin Time is added. If Thrombin Time is normal, PTT 1:1 mix is added. If Thrombin time is abnormal, Reptilase Time is added. If Reptilase time is abnormal, PTT 1:1 mix is added. If Reptilase Time is normal, PTT Heparin Neutralization is added. If PTT Heparin Neutralization is abnormal, PTT 1:1 mix is added. If PTT 1:1 mix is abnormal, Platelet Neutralization procedure is added. If DRVVT is abnormal, DRVVT 1:1 mix is added. If DRVVT 1:1 mix is abnormal, DRVVT confirmation is added. If Platelet Neutralization procedure and DRVVT confirmation are normal or if one is normal and the other not done, Hexagonal Phospholipid Neutralization is added. Additional charges may apply.
*	Reflex dRVVT 1:1 Mix	85613	\$12.73	
*	Reflex dRVVT Confirmation	85613	\$29.55	
*	Reflex Platelet Neutralization	85597	\$48.23	
*	Reflex Thrombin Time	85670	\$13.88	
*	Reflex Reptilase Time	85635	\$24.38	
*	Reflex PTT Heparin Neutralized	85730 85525	\$48.38	
*	Reflex Hexagonal Phospholipid Neutralization	85597	\$162.50	
<input type="checkbox"/>	Anticardiolipin Antibodies (IgG and IgM)	86147	\$90.00	
<input type="checkbox"/>	Anti-β₂-glycoprotein I Antibodies (IgG, IgM, IgA)	86146	\$120.00	

SELECT FROM THE FOLLOWING

LABELING INSTRUCTIONS

Label sample tubes with the patient name, ID, date and time of draw, and location

SHIPPING INSTRUCTIONS

Ship by express mail Monday - Thursday only. Do not ship on Friday or the day before a federal holiday. Ship vial in crush proof packaging and a leak proof bag. Sample should be frozen and shipped on dry ice or an ice pack. Acceptable results also can be obtained from room temperature specimens received within 24 hours of **DRAW TIME**.

BILLING AND RESULTS

An invoice and a copy of the test results will be mailed to your lab or office at the address you provide. **We DO NOT bill the patient's insurance directly.** The lab or ordering doctor's office is responsible for payment of the bill. Please use the claim form we send you to fill in the appropriate diagnosis and forward to the patient's insurance.

Patient Name: _____ Time & Date of Draw: ___/___/___ :___:___
 Patient D.O.B: _____ Time & Date Frozen: ___/___/___ :___:___
 Patient SSN/MRN: _____

TEST REQUESTED	SCREENING	SECONDARY BATTERY
	<input type="checkbox"/> Entire testing Battery (include all antibodies below)	<input type="checkbox"/> If ACL testing is negative perform reflex testing with B2GPI antibodies
	<input type="checkbox"/> Anticardiolipin Antibodies (IgG IgM)	<input type="checkbox"/> If Lupus Anticoagulant is positive, perform reflex testing
	<input type="checkbox"/> Anti-Beta-2-Glycoprotein I (IgG IgM IgA)	
	<input type="checkbox"/> Lupus Anticoagulant	

Ordering Physician: _____ Phone Number: (____) _____ ICD 9 CODE _____
 Hospital or Clinic Name: _____
 Send Results and Billing to: _____
 Check here if you would like results to be faxed.
 Fax Number: (____) _____

LAB LAB USE ONLY: Specimen received on ___/___/___ Time: ___:___ Frozen _____ Room Temp. _____