SUBJECT: PREGNANCY SCREENING LAB SPECIMEN LABELING AND HANDLING	POLICY # PTH-900
MAGEE-WOMENS HOSPITAL OF UPMC	PAGE: 1 OF 6
EFFECTIVE DATE: MARCH 2012	
APPROVED BY: DR. W. ALLEN HOGGE, M.D.	

PURPOSE:

To inform staff of the proper labeling, handling and transport requirements of genetics specimens (i.e. blood or amniotic fluid).

SPECIMEN AND REQUISITION LABELING

I. All specimens must be labeled with a minimum of the following:
   A. Patient's complete first and last name
   B. Medical record number (if unknown, social security number is acceptable if available)
   C. Date and time of specimen collection
   D. Initials of the person responsible for specimen collection

II. All specimens must be accompanied by a requisition (Attachment A - First Trimester Screening Requisition, Attachment B – Multiple Marker Screening requisition) and should include:
   A. Patient's complete first and last name
   B. Medical record number (if unknown, social security number is acceptable if available)
   C. Date of birth
   D. Physician/surgeon name legally authorized to submit specimen as well as address/phone/fax for where report is to be communicated.
   E. Pertinent medical history such as gestational age, maternal weight, diabetic status, multiple pregnancy.
   F. Date and time of collection
   G. Specification of tests being requested.

CORRECTION OF UNLABELED/MISLABELED SPECIMEN

I. Definition
   A. Mislabeled specimen – discrepancy of patient identification information between label, requisition and/or order.
   B. Unlabeled specimen – No label on the specimen.
   C. Due to the irreplaceable (critical) aspect of most genetics specimens, all attempts will be made to accurately correct labeling errors before discarding and attempting to recollect the specimen (when applicable).

II. Labeling errors identified by genetics staff:
   A. Genetics staff will identify the labeling error and contact the collector (or appropriate representative) from the office/unit to explain the error.
   B. Genetics staff will decide if specimen/requisition will be:
      i. Corrected by communication over the phone or a correction may be sent/faxed to the lab.
      ii. Corrected by office personnel who must come to the genetics lab to correct a specimen.
   C. Once the issue is corrected, the specimen will be processed accordingly.

SPECIMEN HANDLING AND TRANSPORT

I. Specimen handling
   A. All specimens should be refrigerated prior to shipment if more than a 12 hour delay between acquiring specimen and shipping/transport of specimen.
   B. The attached chart (Attachment C) details collection and handling of different specimen types.
   C. Sites should contact the pregnancy screening lab (412-641-4057) regarding questions of specimen handling and transport.

II. Specimen Packaging
   A. The primary specimen containers should be plastic and leak-resistant.
   B. Each primary container should have an individual label affixed to the outside of the container that includes the patient/collection information (detailed in section General Information: Specimen and Requisition Labeling).

Date of Initial Issue: March 2012.

Last Effective Date: N/A

Review Dates: N/A

Revision Dates: N/A

Other committee or person approval dates: N/A

Rationale:

☒ Regulatory Agency
☒ Clinical Practice
☐ Unit Operations

Responsible Person: Supervisor Pregnancy Screening Laboratory

Attachment A

Magee-Womens Hospital Pregnancy Screening Laboratory

of the University of Pittsburgh Medical Center

300 Halket Street
Pittsburgh, PA 15213-3180
(412) 641-4878
(412) 641-4057
(412) 641-8730 (Fax)

FIRST TRIMESTER SCREENING REQUISITION

INCOMPLETE INFORMATION MAY RESULT IN DELAYED OR INACCURATE INTERPRETATION OF RESULTS. PLEASE PROVIDE *ALL* INFORMATION REQUESTED.

PATIENT INFORMATION (Please print)

LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH ____/____/_____ SOCIAL SECURITY NUMBER _____/_____/_____

RACE _____ WEIGHT (Pounds) _____

PREGNANCY/SPECIMEN INFORMATION

Specimen Date ____/____/_____ Date of LMP ____/____/_____

Ultrasound Date ____/____/_____ Sonographer Name: _____

Twin Pregnancy? ☐ Yes ☐ No If Twins: ☐ Monochorionic ☐ Dichorionic ☐ Uncertain

Baby A

CRL: _____ (mm) = _____ (wk/day)

NT: _____ (mm)

If Twins, Baby B

CRL: _____ (mm) = _____ (wk/day)

NT: _____ (mm)

OB complications? _____ Major maternal diseases? _____

Is the patient diabetic? ☐ Yes ☐ No If yes, method of control? ☐ Insulin ☐ Diet ☐ Oral Meds _____

Assisted Reproduction? ☐ Yes ☐ No If donor egg, age of donor _____ yrs.
If frozen embryo, age at collection _____ yrs.

FAMILY HISTORY (If yes, what is the relationship to the patient?)

Spina Bifida/Anencephaly ☐ Yes ☐ No _____

Down syndrome ☐ Yes ☐ No _____

Other Birth Defects - ☐ Yes ☐ No (If Yes, Describe) _____

REFERRING PHYSICIAN INFORMATION

(Please include a physician signature and diagnosis code if a script will not be accompanying the patient)

REFERRING PHYSICIAN (Print) _____ PHONE _____ FAX _____

(Signature) _____ DIAGNOSIS CODE _____

OFFICE ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

INCOMPLETE INFORMATION MAY RESULT IN DELAYED OR INACCURATE INTERPRETATION OF RESULTS. PLEASE PROVIDE *ALL* INFORMATION REQUESTED.

PATIENT INFORMATION (Please print)

LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH ____ / ____ / ____ SOCIAL SECURITY NUMBER ____ / ____ / ____

MEDICAL ASSISTANCE NUMBER (if applicable) _____

PREGNANCY/SPECIMEN INFORMATION

SPECIMEN DATE ____ / ____ / ____ ☐ FIRST SAMPLE ☐ REPEAT SAMPLE

RACE _____ IS PATIENT INSULIN DEPENDENT DIABETIC? ☐ YES ☐ NO

DID PATIENT HAVE:
CVS? ☐ YES ☐ NO
First Trimester Screen*? ☐ YES ☐ NO
*Do you want AFP only? ☐ YES ☐ NO

WEIGHT (POUNDS) _____ DATE OF LMP ____ / ____ / ____

ULTRASOUND DATE IF AVAILABLE ____ / ____ / ____ BPD (WEEKS) _____ COMPOSITE _____ NORMAL? ☐ YES ☐ NO

MULTIPLE PREGNANCY? ☐ YES ☐ NO ☐ TWINS ☐ OTHER (#) _____

OB COMPLICATIONS _____

MAJOR MATERNAL DISEASES? _____

FAMILY HISTORY — IF YES, RELATIONSHIP TO PATIENT

☐ YES ☐ NO SPINA BIFIDA/ANENCEPHALY _____

☐ YES ☐ NO DOWN SYNDROME _____

☐ YES ☐ NO OTHER BIRTH DEFECTS - IF YES, DESCRIBE _____

REFERRING PHYSICIAN INFORMATION

(Please include a physician signature and diagnosis code if a script will be accompanying the patient)

REFERRING PHYSICIAN (Print) _____ PHONE _____ FAX _____

(Signature) _____ DIAGNOSIS CODE _____

OFFICE ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Magee-Womens Hospital
of University of Pittsburgh Medical Center

Genetics Department
Tel: (412) 641-4168 / Fax (412) 641-8730

SPECIMEN/TEST REQUEST

31280-000PS Rev. 07/06

Multiple Marker Screening

Attachment C

PREGNANCY SCREENING LABORATORY TESTS
Department of Genetics
Magee-Womens Hospital

TEST	METHOD OF COLLECTION/TYPE OF COLLECTION	ADDITIONAL COLLECTION INSTRUCTION	COMMENTS	ASSAY TIME	RESULTS FORWARDED WITHIN
Peripheral Blood – 1st trimester screening	5-8 ml in serum separator tube (SST) or red top tube.	Must be accompanied by completed **First Trimester Screening Requisition.**	-Preferably received in lab same day. -SST (must be spun) can be sent within 7 days -Whole blood must be within 24 hours	48-72 hours	7 days
Peripheral Blood – 2nd trimester screening	5-8 ml in serum separator tube (SST) or red top tube.	Must be accompanied by completed **Multiple Marker Screening Requisition.**	-Preferably received in lab same day. -SST (must be spun) can be sent within 7 days -Whole blood must be within 24 hours	48-72 hours	7 days