Children's Hospital of Philadelphia
Pathology & Laboratory Medicine

CORE LABORATORY: BLOOD GAS REQUISITION

Robert W. Doms, M.D., Ph.D., Pathologist-in-Chief

PATIENT NAME: SEX: M F

MRN:

AGE / DATE OF BIRTH:

Collection Date: _____

ACCT #:

Collection Time: _____

CLIENT IDENTIFIER: _____

Date: _____

Diagnosis / ICD-10: _____

Ordering Physician / CRNP: _____

Ordering Location: _____

ASCOM or Ext: _____

Please Fax Lab Results To: _____

Physician, CRNP, or Designee *Name (please print):* _____ ***Signature:*** _____

Patient temperature: _____

Collection site: _____

FiO2: _____

Arterial Panels	
BGP	□ Blood Gas Panel
SGP	□ Super Blood Gas Panel
SGPL	□ Super Blood Gas Panel w/Lactate

** All panels include hemoglobin and hematocrit*

Venous Panels	
BGPV	□ Blood Gas Panel, Venous
SGPV	□ Super Blood Gas Panel, Venous
SGPLV	□ Super Blood Gas Panel w/Lactate, Venous

** All panels include hemoglobin and hematocrit*

Other Panels	
Pre-ECMO	□ Blood Gas Panel, Pre-ECMO
Post-ECMO	□ Blood Gas Panel, Post-ECMO
BGPC	□ Blood Gas Panel, Cord Blood
THB	□ Total Hemoglobin & Hematocrit

Individual Tests	
INA	□ Na+ (sodium)
IK	□ K+ (potassium)
ICA	□ Ionized Ca2+
ICA-CVVH	□ Ionized Ca2+, CVVH
PGLU	□ Glucose
ILAC	□ Lactate
ICL	□ Cl- (chloride)
COOX	□ Co-oximetry
GLCON	□ Glucose, confirmatory

Other Tests	
IOSMP	□ Osmolality, plasma
IOSMU	□ Osmolality, urine
IOSBF	□ Osmolality, body fluid (stool)

Other Tests / Comments:

_____

_____

By using and sending this Requisition Form to CHOP Outreach Lab for laboratory testing, you, the sender, acknowledge and agree that you have read and agree to the CHOP Terms and Conditions posted at www.chop.edu/labs and agree to pay CHOP the rates in CHOP's fee schedule in effect on the date the specimen is received.