Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Iothalamate Test Request

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Street Address		
City	State	ZIP Code

Reason for Testing (required)

ICD-10 Diagnosis Code

Note: It is the client's responsibility to maintain documentation of the order.

New York State Patients: Informed Consent for Genetic Testing

"I hereby confirm that informed consent has been signed by an individual legally authorized to do so and is on file with this office or the individual's provider's office."

Signature ▶

Note: Test requests without a signature will not be performed.

Patient Information (required)

Patient ID (Medical Record No.)	
Patient Name *(Last, First, Middle)*	
Sex ☐ Male ☐ Female	Birth Date *(mm-dd-yyyy)*
Collection Date *(mm-dd-yyyy)*	Time ☐ am ☐ pm

Submitting Provider Information (required)

Submitting/Referring Provider Name *(Last, First)*

Fill in only if Call Back is required.

Phone (with area code)	Fax (with area code)
National Provider Identification (NPI)	

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

MCL Internal Use Only

Ship specimens to:

Mayo Clinic Laboratories
3050 Superior Drive NW
Rochester, MN 55905

Customer Service: 855-516-8404

Visit www.MayoClinicLabs.com for the most up-to-date test and shipping information.

Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing-related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

T890
MC1360-06rev0723

Patient Information (required)

Patient ID (Medical Record No.)	Client Account No.
Patient Name *(Last, First, Middle)*	Client Order No.
Birth Date *(mm-dd-yyyy)*	

General Collection and Processing Instructions

If questions, call the Renal Laboratory at 507-284-2525 and ask for a Technical Specialist. **Precise recording of collection times and urine volume is essential for this test**. Record all information in the spaces provided to the right.

1. **Record patient's weight and height.**
2. **UO – Initial Pre-injection Urine Sample**
   - Collect urine before injection of Iothalamate.
   - Aliquot 5 mL urine into one of the 10-mL urine containers.
   - On the right, record collection time to the nearest minute.
   - Write "UO" on the urine container.
   - If the patient cannot void, write "no specimen" on U0 label and continue with testing.
3. **Iothalamate Injection Time**
   Record the injection time to the nearest minute.
4. **UE – Equilibration Urine Collection**
   - Collect urine 60 minutes after the iothalamate injection time.
   - Minimum urine output of 30 mL is required. Follow bladder scanning parameter instructions.
   - On the right, record the collection time to the nearest minute.
   - Quantitatively measure UE volume to the nearest mL and record below.
   - Aliquot 5 mL urine into the second 10-mL urine container.
   - Write "UE" on the urine container.
5. **P1 – Plasma**
   - Collect a sodium heparin blood within 5 minutes (maximum time 10 minutes, see detailed instructions) of collecting the UE. It is important to use opposite arm of SQ injection.
     If it takes more than 10 minutes to obtain blood specimen:
     - Patient must re-void **immediately** after blood draw.
     - Add additional urine to beaker, weigh, and record total volume.
     - Aliquot urine in "UE" labeled tube and blood in "P1" labeled tube.
   - On the right, record the collection time to the nearest minute.
   - Spin blood and aliquot 1-mL plasma into the tube provided.
   - Write "P1" on the vial.
6. **U1 – GFR Testing Urine Collection**
   - Collect urine 45 minutes after the UE void time.
   - Minimum urine output of 100 mL is required. Follow bladder scanning parameter instructions.
     - If 100 mL output is not met, ask patient to re-void every 20 minutes until 100 mL output is obtained.
   - Quantitatively measure the U1 volume to the nearest milliliter.
   - On the right, record the following information for the U1 collection:
     a. Collection Time (to the nearest minute)
     b. Volume (to the nearest milliliter)
     c. Collection Duration (to the nearest minute)
     - Duration time: the minutes between UE and U1 void time
   - Aliquot 5 mL into the third 10-mL urine container.
   - Write "U1" on the urine container.
7. **P2 – Plasma**
   - Collect a sodium heparin blood within 5 minutes (maximum time 10 minutes, see detailed instructions) of collecting the U1. It is important to use opposite arm of SQ injection.
     If it takes more than 10 minutes to obtain blood specimen:
     - Patient must re-void **immediately** after blood draw.
     - Add additional urine to beaker, weigh, and record total volume.
     - Aliquot urine in "U1" labeled tube and blood in "P2" labeled tube.
   - Below, record collection time to the nearest minute.
   - Spin blood and aliquot 1-mL plasma into the tube provided.
   - Write "P2" on the vial.
8. **Troubleshooting (refer to detailed instructions)**
   - Re-collection for stool contaminated urine specimens.
   - Difficulty emptying bladder.
   - Blood collection difficulty, longer than 10 minutes maximum from void time.
9. **Indicate name and phone number of a person that can answer any questions MCL may have regarding the collection of these specimens.**

Packing Instructions

1. **Ensure that all specimens are labeled correctly.**
2. Put the plasma and urine aliquots into the "Pink Refrigerated Specimen" transport bag.
3. Insert a copy of the completed requisition form into outer pocket of transport bag.
4. Store the specimens in the refrigerator until the specimens are shipped.
5. Ship the specimens at refrigerate temperature.

Test NSRC / Iothalamate, Glomerular Filtration Rate, Plasma and Urine

The following information must be provided before testing can be completed.

1. Patient Weight _____ kg (in kilograms)
   Patient Height _____ cm (in centimeters)
2. Initial Urine Collection Time (UO) _____ : _____ ☐ am ☐ pm
3. Iothalamate Injection Time _____ : _____ ☐ am ☐ pm
4. Equilibration Urine (UE) Collection Time _____ : _____ ☐ am ☐ pm
   UE Collection Volume _____ mLs
5. Plasma (P1) Collection Time _____ : _____ ☐ am ☐ pm
   (Must be no longer than 5 minutes after UE Collection)
6. a. U1 Testing Urine Collection Time _____ : _____ ☐ am ☐ pm
   b. U1 Collection Volume _____ mLs
   c. U1 Collection Duration _____ minutes
7. Plasma (P2) Collection Time _____ : _____ ☐ am ☐ pm
   (Must be no longer than 5 minutes after U1 Collection)
8. Collection Facility
   Contact Name:
   Phone:

Print