



ARUP DIRECT SUBMISSION TESTING INSTRUCTIONS

The following process is for when a client must submit a specimen(s) **DIRECTLY** to an approved ARUP referral laboratory due to short stability (less than 72 hours).

NOTE: The process of placing a direct submit order with ARUP Referral Testing (RT) takes approximately one hour to complete. Please allow adequate time between specimen collection and scheduled FedEx pickup to complete the process.

Please see the ARUP test directory at aruplab.com, the referral laboratory website, or call 1-800-242-2787 for test requirements and/or test research and further questions before drawing a specimen. Be aware that referral laboratories can have restrictions on days of the week that testing is performed. Holidays are evaluated on a case-by-case basis.

NOTE: Specimen(s)/testing can be rejected by the referral laboratory if test and/or specimen requirements are not met and/or specimen(s) arrive past published stability or on a day testing is not accepted by the referral laboratory.

Client Responsibilities/Steps:

- Client completes the form on pages 3 and 4 per patient order.
- Submit to ARUP RT by encrypted email at referraltestingdirectsubmits@aruplab.com
 - **WITH** the email subject line of "FedEx Pick Up (time and time zone)"
 - Faxing 801-584-5087 is NOT recommended but is acceptable.

NOTE: If the FedEx pick up time is within one hour or less of completing this form, please call ARUP RT at 800-242-2787 ext. 5161 within five minutes of sending this form to alert ARUP RT of urgency due to FedEx pick up time. Use "FedEx Pick Up (time and time zone) Urgent" as the subject line of the email.

ARUP RT Responsibilities/Steps:

- Review the information provided by the client in the form on pages 3 and 4.
- Locate the transmitted order in ARUP's LIS or register the patient (manual orders only) in the ARUP LIS.
- Generate and fax or email the necessary paperwork (packing list, requisitions, airway bill, etc.) that **MUST** accompany the specimen(s) to the referral laboratory.

NOTE: Submit only ARUP-provided packing lists or requisitions with the specimen(s) to avoid any billing or reporting issues.

- Monitor pending test orders.
- Report results upon receipt from the referral laboratory.

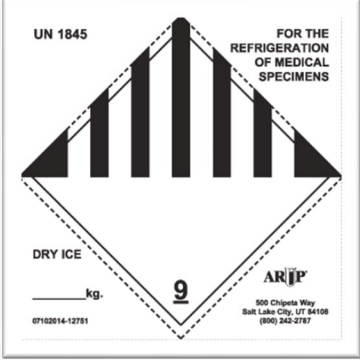
NOTE: ARUP RT will call the client with any questions or missing information as needed. **Missing information will delay the direct submit process.** If ARUP RT cannot obtain the missing information, the ARUP exception handling process will be used. ARUP will also address any rejection or issues with specimens or testing communicated from the referral laboratory through the ARUP exception handling process.

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Client Packing/Shipping:

Upon receipt of the required paperwork from ARUP RT, the client will pack and ship the specimen(s) and paperwork **DIRECTLY** to the referral laboratory as indicated, using the ARUP provided FedEx airway bill (AWB)/shipping label.

Secure the ARUP provided FedEx AWB/shipping label to the box with a FedEx envelope sleeve or packing tape. Ensure the AWB/labeling is protected.

Temperature	Packing Instructions
	NOTE: It is extremely important to carefully pack the specimen container(s)/tube(s), providing ample protection against breakage. Use a Styrofoam box made for shipping diagnostic specimens. Place the Styrofoam box inside a cardboard box.
Ambient/room temperature	Ship at ambient/room temperature with no cold packs or dry ice.
Refrigerated	<p>Place two refrigerated cold packs on top of/next to the specimen(s). Include more cold packs when packing more than one specimen.</p> <p>NOTE: The cold packs need to be refrigerated for at least 48 hours before shipping.</p>
Frozen	<ul style="list-style-type: none">• Include at least 2.2 kg of dry ice with the specimen. Include more dry ice when packing more than one specimen.• Place dry ice on top of specimen(s).• Include a class 9 hazardous material label on the box, labeled with the appropriate weight of dry ice (see image). 

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NOTE: See the ARUP test directory at aruplab.com, the referral laboratory website, or call 1-800-242-2787 for test requirements and/or test research and further questions BEFORE drawing a specimen.

NOTE: Complete one form per patient. If multiple specimen types, please use A) and B) fields.

Patient Name: _____ Date of Birth: _____
Full Name of Person Completing Form: _____ Call Back Phone: _____
Client Facility Name and ID: _____ Date: _____
Reference Number Provided by ARUP as Applicable: _____ Date: _____

How will the required referral laboratory paperwork come back to you?

☐ Secure fax: _____ ☐ Secure email: _____

FedEx Pick Up Time: _____ Time Zone: _____

Are you using an airway bill (AWB) already provided by ARUP RT for the same referral lab on the same day or an AWB from a referral lab kit? ☐ No ☐ Yes If yes, AWB number/Case Ref #: _____

How will the order be placed? ☐ Electronic order (Connect or Interface) ☐ Manual by fax (801-584-5087)

NOTE: ARUP Manual REQ (eSupply #32916) must be submitted for all manual orders.

#1 Full Test Name: _____

Performing/Referral Laboratory Name: _____

Test Code, as applicable: _____

ARUP Accession: _____ Client Patient ID/MRN on the Specimen: _____

A) Date/Time of Collection (CDT) With Time Zone: _____ Specimen Type: _____

Number/Quantity of Specimens: _____ Total Volume: _____

Specimen Temperature: ☐ Ambient/Room Temperature ☐ Refrigerated ☐ Frozen

B) Date/Time of Collection (CDT) With Time Zone: _____ Specimen Type: _____

Number/Quantity of Specimens: _____ Total Volume: _____

Specimen Temperature: ☐ Ambient/Room Temperature ☐ Refrigerated ☐ Frozen

#2 Full Test Name: _____

Performing/Referral Laboratory Name: _____

Test Code, as applicable: _____

ARUP Accession: _____ Client Patient ID/MRN on the Specimen: _____

A) Date/Time of Collection (CDT) With Time Zone: _____ Specimen Type: _____

a. Number/Quantity of Specimens: _____ Total Volume: _____

b. Specimen Temperature: ☐ Ambient/Room Temperature ☐ Refrigerated ☐ Frozen

B) Date/Time of Collection (CDT) With Time Zone: _____ Specimen Type: _____

Number/Quantity of Specimens: _____ Total Volume: _____

Specimen Temperature: ☐ Ambient/Room Temperature ☐ Refrigerated ☐ Frozen

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#3 Full Test Name: _____

Performing/Referral Laboratory Name: _____

Test Code, as applicable: _____

ARUP Accession: _____ Client Patient ID/MRN on the Specimen: _____

A) Date/Time of Collection (CDT) With Time Zone: _____ Specimen Type: _____

a. Number/Quantity of Specimens: _____ Total Volume: _____

b. Specimen Temperature: ☐ Ambient/Room Temperature ☐ Refrigerated ☐ Frozen

B) Date/Time of Collection (CDT) With Time Zone: _____ Specimen Type: _____

Number/Quantity of Specimens: _____ Total Volume: _____

Specimen Temperature: ☐ Ambient/Room Temperature ☐ Refrigerated ☐ Frozen

Additional Information:

Ordering Physician name: _____ ☐ N/A

Physician NPI #: _____ ☐ N/A

Diagnosis/ICD-10 Code: _____ ☐ N/A

Reason for Testing: _____ ☐ N/A

Drug/Antibiotic Use: _____ ☐ N/A

Allergy Information: _____ ☐ N/A

Will any of the following be included?

☐ Pathology reports, Patient/Clinical History forms, Signed Consent forms, Signed Requisition, etc.

☐ No extra documents/information will be submitted to ARUP RT.

Clients located in New York state ONLY:

If testing is not NYDOH approved, the referral laboratory is responsible for submitting a single use permit (SUP). If denied, they will communicate with ARUP, who will notify you of the denial. Refer to wadsworth.org as needed.

Comments/Additional Information:

For questions, contact Referral Testing 1-800-242-2787
