

**Reporting Title:** HEV IgM Ab Screen, S

**Performing Location:** Rochester

**Necessary Information:**

Date of collection is required.

**Specimen Requirements:**

**Collection Container/Tube:** Serum gel

**Submission Container/Tube:** Plastic vial

**Specimen Volume:** 0.5 mL

**Collection Instructions:**

1. Centrifuge blood collection tube per collection tube manufacturer's instructions (eg, centrifuge within 2 hours of collection for BD Vacutainer tubes).
2. Aliquot serum into plastic vial.

**Forms:**

If not ordering electronically, complete, print, and send a [Gastroenterology and Hepatology Client Test Request \(T728\)](#) with the specimen.

Specimen Type	Temperature	Time	Special Container
Serum SST	Frozen (preferred)	0 hours	
	Refrigerated	24 hours	

**Result Codes:**

Result ID	Reporting Name	Type	Unit	LOINC
86212	HEV IgM Ab Screen, S	Alphanumeric		14212-5

LOINC and CPT codes are provided by the performing laboratory.

**Supplemental Report:**

No

**CPT Code Information:**

86790

**Reflex Tests:**

Test Id	Reporting Name	CPT Units	CPT Code	Always Performed	Available Separately
HEVML	HEV IgM Ab Confirmation, S	1	86790	No	Yes

**Result Codes for Reflex Tests:**

Test ID	Result ID	Reporting Name	Type	Unit	LOINC
HEVML	61903	HEV IgM Ab Confirmation, S	Alphanumeric		14212-5

**Reference Values:**

Negative