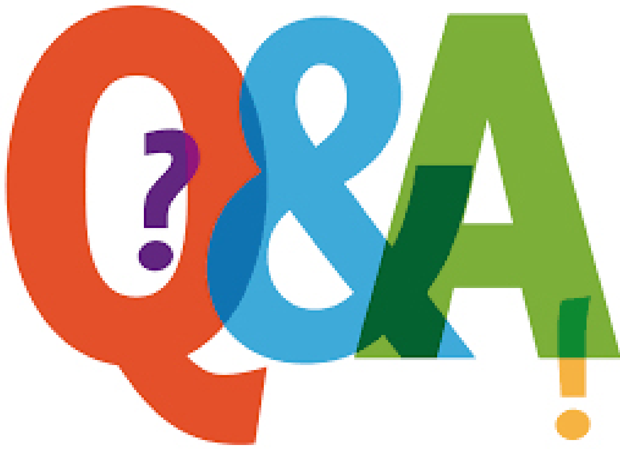

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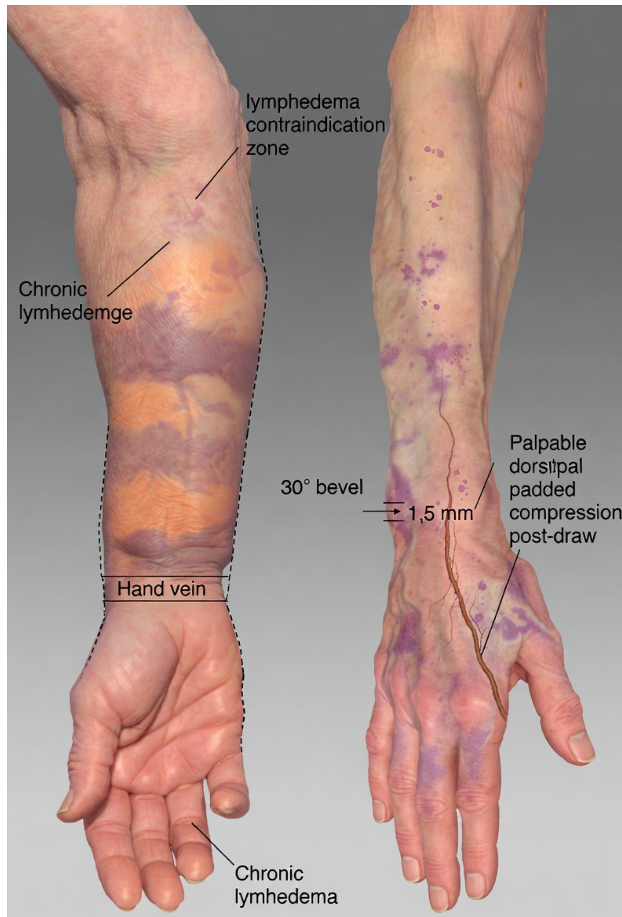
Question: 1420

A 92-year-old frail geriatric resident in hospice with end-stage renal disease and expressive aphasia (non-verbal) needs a BMP for palliative electrolyte check. The social worker verifies name and MRN via proxy directive and chart, but the patient has bilateral mastectomies (left 2018, right 2022) causing severe lymphedema in both arms. No IVs, but skin is paper-thin with ecchymoses; a faint dorsal hand vein is palpable on the right.



Addressing aphasia, lymphedema contraindications, and frailty, what is the safest site preparation sequence to facilitate the draw while upholding comfort?

A. Use capillary earlobe for BMP, as veins are inaccessible.

B. Confirm via social worker proxy and MRN, position semi-Fowler for comfort, choose right dorsal hand

vein, cleanse with tincture of iodine drying 1 minute, insert 25-gauge butterfly with extra padding.
C. ID with MRN alone, select left forearm despite edema, use 23-gauge at 45 degrees after brief alcohol swipe.
D. Attempt antecubital on right, ignoring mastectomy history, with verbal cues to patient.

Answer: B
Explanation: Non-verbal aphasic patients rely on advance directive-authorized proxies like social workers for ID verification alongside MRN, ensuring ethical consent in hospice without exploiting vulnerability. Bilateral mastectomies render all upper extremity sites on affected sides absolute contraindications due to lymphedema exacerbation risks (infection, cellulitis), restricting to contralateral hand veins if unilateral, but here both sides preclude arms—wait, question specifies bilateral, so hands are extensions but dorsal metacarpals are acceptable if distal and non-edematous. Semi-Fowler positioning enhances venous filling in frail elders, reducing syncope. Tincture of iodine (2%) offers durable antisepsis for thin skin prone to tears, drying 1 full minute to prevent chemical irritation; 25-gauge butterfly minimizes vessel trauma in 1-2 mm hand veins, at 30-degree angle with bevel up. Post-draw, padded compression (3-5 minutes) prevents re-bleeding in coagulopathic renal patients, with gentle explanation via gestures promoting dignity, per 2023 Hospice Phlebotomy Consortium updates for end-of-life care.

Question: 1421

After drawing blood into a light blue top tube for coagulation studies, the technician accidentally shakes it vigorously. What effect will this have on test results?

A. It has no effect as the additive stabilizes the blood
B. It can cause clot formation and inaccurate coagulation test results
C. It improves mixing and sample accuracy
D. It neutralizes interfering lipids in the sample

Answer: B
Explanation: Vigorous shaking can cause hemolysis or clotting, compromising coagulation test results. Proper gentle inversion is necessary to mix additives without damaging cells.

Question: 1422

During a home health visit, a phlebotomy technician draws a D-dimer assay from a 50-year-old immobile patient with suspected deep vein thrombosis (DVT). The level is 3,500 ng/mL, critically elevated above 500 ng/mL, indicating high clot burden. The supervising nurse is delayed in traffic, the patient's hospice coordinator is on-site but not ordering, and results must route to the vascular specialist via faxed report per agency policy. The patient's live-in aide, trained as a CNA, overhears the portable analyzer readout and presses for interpretation to "help with care planning." The visit occurs in the patient's open-concept living room with windows to neighbors. How should the technician manage this high-stakes reporting while safeguarding sensitive information?

A. Securely fax the critical value to the specialist immediately, then politely redirect the aide without details
B. Wait for the nurse's arrival to co-report, using the delay to educate the aide on general DVT symptoms
C. Interpret the result for the aide to empower non-professional support and fax the report later
D. Enter the result into a shared app visible to the team and discuss implications openly with the aide present

Answer: A
Explanation: Elevated D-dimer demands stat specialist notification via secure fax for anticoagulation initiation, as delays in DVT management risk pulmonary embolism; agency policy ensures chain-of-custody documentation. Redirecting the aide upholds HIPAA by limiting PHI to minimum necessary for their role, preventing misinterpretation that could induce anxiety or errors. Interpretation exceeds phlebotomy scope, risking misinformation. Waiting prolongs critical intervention, and shared apps or open discussions in visible spaces violate privacy safeguards, especially in home settings where third-party exposure is heightened.

Question: 1423

Infant with geriatrics-like dehydration (NEC suspicion) needs CRP. Age 1 month, veins thread-like, obese from TPN BMI equiv 25. What micro-technique?

A. Heel stick with 1.5 mm lancet, SST microtube.
B. Scalp temporal, 28-gauge.
C. Umbilical stump, no.
D. Central labs draw.

Answer: A
Explanation: Dehydrated neonates mimic geriatric collapse; heel capillary standard for CRP (<0.5 mg/dL

NeoReviews prioritizes peripheral micro for sepsis rules.

Question: 1424

A phlebotomy continuing education course introduces a new CLSI guideline requiring a maximum of two venipuncture attempts per patient. How does adopting this guideline improve quality assurance?

A. Limits phlebotomy workload without impacting quality outcomes
B. Reduces patient discomfort and risk of complications while ensuring sample quality
C. Primarily benefits documentation rather than patient care
D. Increases procedure time but guarantees specimens are always obtained

Answer: B
Explanation: Limiting attempts protects patient safety and comfort, reducing errors and poor-quality specimens, aligning with quality assurance goals.

Question: 1425

In oncology infusion center, technician for CBC assembles 22-gauge safety needle, gel tourniquet, inserts bevel-up at 22 degrees into basilic after anchoring. During fill, green discoloration appears in tube with patient reporting metallic taste and dyspnea. What toxic complication from equipment leaching occurred, and what chelation is indicated?

A. Aluminum toxicity; EDTA infusion.
B. Latex hypersensitivity; epinephrine IM.
C. Silicone embolism; deferoxamine mesylate.
D. PVC phthalate release; dimercaprol.

Answer: D
Explanation: Green discoloration with taste and dyspnea indicates phthalate leaching from degraded PVC tubing in the needle holder, causing acute chemical pneumonitis in oncology patients with barrier

supportive ventilation. Silicone is white; latex anaphylactic; aluminum chronic.

Question: 1426

A phlebotomy technician is exposed to a needle puncture from a patient positive for HBsAg. The technician has completed vaccination but no serologic testing completed. What care is required?

A. No further action needed
B. Administer booster dose and test anti-HBs titer
C. Observe and test after 6 months only
D. Start PEP for hepatitis B immediately

Answer: B
Explanation: The next step is testing anti-HBs to confirm immunity; if low antibody levels, a booster dose is recommended to provide adequate protection against HBV.

Question: 1427

A phlebotomist is preparing to draw blood from a patient who is a minor. The patient's mother provides the name and date of birth, but the wristband shows a different name. What should the phlebotomist do?

A. Verify the wristband against the medical record and consult the nurse
B. Trust the mother's information and proceed with the draw
C. Use the medical record number without further verification
D. Ask the child for their name and date of birth to confirm

Answer: A
Explanation: The phlebotomist should verify the wristband against the medical record and consult the nurse to resolve the discrepancy. This ensures that the minor is accurately identified before the blood draw.

Question: 1428

You are to collect a blood sample from a patient on airborne plus contact isolation for COVID-19. What PPE should you don before entering the room?

A. N95 respirator, gown, gloves, face shield
B. Surgical mask and gloves only
C. Gown and gloves only
D. N95 respirator and gloves only

Answer: A
Explanation: COVID-19 precautions often require airborne and contact precautions including N95 respirators, gown, gloves, and face shields to protect from droplet and airborne transmission.

Question: 1429

A phlebotomist uses a butterfly needle equipped with a spring-loaded safety retractor. After collecting blood, the needle does not retract when the button is pressed. What is the proper next step?

A. Remove the needle completely and dispose of it immediately in the sharps container without recapping

B. Continue pressing the button until the mechanism activates
C. Manually retract the safety cover using the other hand
D. Recap the needle carefully with one hand to protect from injury

Answer: A
Explanation: OSHA forbids recapping needles due to increased injury risk. If the safety retraction mechanism fails, the needle should be disposed of immediately in the sharps container without attempts to recap or manually retract it. Persistently pressing the button or manually handling the needle increases exposure risk. Immediate safe disposal and reporting the device failure ensures protection.

Question: 1430

VTE risk factor protein C (70-140%), citrate tube but tourniquet >3min (stasis low 10%), contaminated IV flush, no ice for activity assay. Label ok. Reject for stasis/contam. Action?

A. Antigen test.
B. Family screen.
C. Repeat activity.
D. Document, notify thrombosis specialist and phleb lead, clean draw.

Answer: D
Explanation: Stasis hemodilutes, contam inhibits, no ice denatures. Notify spec (message: "Prot C reject—

false pos 18%.

Question: 1431

A phlebotomy technician in an infectious disease ward draws quant iron studies (ferritin 800 ng/mL suspected) from a patient with visceral leishmaniasis under contact precautions, splenomegaly grade 3,

tropical protocols, what pre-draw amastigote screen integration with PPE avoids iatrogenic spread?

A. Review peripheral smear history, gown/gloves, draw SST from median basilic, clot 30 min
B. Bedside thick smear first, N95, use butterfly for spleen proximity, freeze serum -20°C
C. PCR log review, surgical mask, EDTA for iron panel, centrifuge high-speed
D. No screen, double gloves, capillary ferritin, vector netting over arm during draw

Answer: A
Explanation: Contact precautions for leishmaniasis (direct fluid contact) require gown/gloves, with smear history review confirming amastigotes to guide safe venipuncture away from spleen (avoids rupture in

clotting yields clear serum; N95 unnecessary; butterfly for access but not vector; capillary volumes insufficient for panels; EDTA hemolyzes iron assays.

Question: 1432

a walk-in participant whose pre-registration via mobile app shows conflicting ethnicity data (self-reported Asian vs. EHR Caucasian from a linked donor history), impacting genomic consent forms for order management. The requisition requires HLA typing addendum verification. Under NIH's updated inclusivity mandates, what demographic verification method best resolves the discrepancy to ensure ethical registration and specimen allocation?

A. Use biometric scan (fingerprint) as proxy for identity, appending both ethnicities to the requisition for downstream adjudication.
B. Escalate to the study coordinator for remote resolution, pausing the participant's slot until alignment.
C. Default to app self-report, noting the conflict in the consent footer without further inquiry to expedite the group draw.
D.
patient narrative and linking to the most recent consented record for unified registration before tube labeling.

Answer: D
Explanation: The structured NIH toolkit interview facilitates narrative-based confirmation, resolving

could skew HLA allele frequencies, leading to erroneous ancestry-linked interpretations. This ensures ethical registration by prioritizing patient autonomy in self-identification while unifying records for accurate order tracking in biobanking. Defaulting risks consent invalidation, escalation delays consortium efficiency, and biometrics don't address demographic nuance required for NIH compliance.

Question: 1433

A phlebotomist for bone marrow donor registry draws 8 mL HLA typing from a 25-year-old. EHR registry links to NMDP, but underfill to 6 mL from small veins. Candidate anxious. What DNA stabilization with EHR candidate portal update accelerates matching?

A. Redraw full, sedating per psych consult.
B. Submit partial, risking allele dropout (15%).
C. Quarantine, buccal swab alternative (0 mL blood), uploading genotype prelim.
D. Add EDTA preservative drop, relabel, and portal-note for high-sensitivity PCR.

Answer: C

Explanation: HLA underfill drops resolution (10-20% dropout, ASHI), delaying matches (wait 3-6 months avg). Buccal swab (99% concordance) preserves volume, with portal transparency boosting retention (80% re-contact rate). Preservative unvalidated; submission flawed; redraw burdensome.

Question: 1434

old with dementia refusing a PT draw (target INR 2.0-3.0). To respect autonomy within scope:

A. Proceeds under implied consent from advance directive
B. Applies gentle physical restraint for procedure completion
C. Delays draw until family arrives for verbal proxy
D. Refers to geriatrics consult for capacity assessment and alternatives

Answer: D
Explanation: Geriatric CE emphasizes dignity, with scope barring coercion; referral invokes ethics committee for non-invasive options like point-of-care INR if incapacity confirmed. This prevents elder

Question: 1435

A 72-year-old patient with a history of chronic kidney disease and recent initiation of warfarin therapy presents for routine blood work including a PT/INR, CBC, and comprehensive metabolic panel. The patient's veins are fragile and sclerosed due to multiple prior dialysis accesses, with visible bruising from recent venipunctures. During assessment, the patient reports a known latex allergy and is currently experiencing mild dehydration from poor oral intake. Which tube should be collected first to ensure accurate coagulation results while minimizing contamination risks from other additives?

A. Light blue-top sodium citrate for PT/INR
B. Gold-top SST for chemistry
C. Lavender-top EDTA for CBC
D. Red-top plain for serum baseline

Answer: A
Explanation: In this scenario, the light blue-top tube containing sodium citrate must be collected first according to CLSI order of draw guidelines to prevent carryover contamination from other anticoagulants or clot activators that could falsely elevate PT/INR values, which are critical for monitoring warfarin efficacy in a patient at high bleeding risk from kidney disease and dehydration. The patient's fragile veins and bruising necessitate gentle technique, but the order remains unchanged; a winged infusion set (23-25 gauge) would be ideal for access, and latex-free gloves and tourniquet must be used due to the allergy. Dehydration may cause hemoconcentration, potentially prolonging PT, so hydration status should be noted

on the requisition. Accurate INR is essential to adjust warfarin dosing and avoid supratherapeutic levels leading to hemorrhage.

Question: 1436

For a 62-year-old renal transplant patient (creatinine 1.8 mg/dL) drawn for tacrolimus level in EDTA tube, post-venipuncture bleeding persists after 4 minutes pressure due to cyclosporine interaction. Tube at 3.5

delays?

A. Apply 9 minutes pressure, aliquot plasma frozen, transport on dry ice to maintain drug-protein binding
B. Elevate and bandage at 6 minutes, refrigerate tube for LC-MS/MS stability
C. Continue 5 minutes, warm site for perfusion, ambient transport with dilution note
D. Document and tube immediately, correlating trough with biopsy for efficacy

Answer: A

pressure (8-10 minutes) to avoid subtherapeutic levels from redraws. Tacrolimus assays require frozen plasma (-20°C min) to preserve 90% stability <24 hours, preventing graft rejection misdiagnosis. Aliquoting minimizes freeze-thaw; refrigeration insufficient; warming exacerbates; immediate risks hemolysis. This optimizes dosing without toxicity.

Question: 1437

During a routine inspection, a technician finds that several sharps containers are overflowing. What is the correct procedure for handling this situation?

A. Push down on the contents to fit more
B. Leave the containers as they are and report it later
C. Seal the containers and replace them with new ones
D. Remove the contents and dispose of them in the trash

Answer: C
Explanation: Overflowing sharps containers pose a significant safety risk. The correct procedure is to seal the containers and replace them with new ones immediately to ensure proper disposal and minimize the risk of needle-stick injuries.

Question: 1438

You find that a requisition for a lipid panel is missing the patient's insurance information required for

billing. Which action aligns best with quality laboratory practices?

A. Collect the specimen and label everything except insurance details, then follow up later
B. Contact the ordering provider or patient to obtain the missing insurance details before proceeding
C. Cancel the order completely and advise a new order with complete insurance information
D. Enter placeholder insurance information in the system to avoid delays in testing

Answer: B
Explanation: Contacting the ordering provider or patient to obtain missing insurance information before specimen collection ensures all necessary information is accurate and complete at the time of processing, preventing billing issues and specimen rejection later. Collecting without correct info or using placeholders violates quality guidelines and leads to processing errors. Canceling should be a last resort after attempts to resolve.

Question: 1439

Which of the following lab values would be most critical to review before performing a phlebotomy on a patient with bleeding risk?

A. Sodium level
B. Blood glucose
C. Potassium level
D. Platelet count

Answer: D
Explanation: Platelet count is critical as low platelets increase bleeding risk during venipuncture and influence the procedure and aftercare [general clinical knowledge].

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