Cincinnati Children's
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Diagnostic Immunology Laboratory
Ph: 513-636-4685 Fax: 513-636-3861
www.cchmc.org/DIL

Test Requisition Form - 012712

Send to: **Julie Beach-Hematology/Oncology R2328**
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue
Cincinnati, OH 45229-3039
MUST be received within 24 hrs of being drawn.
Maintain all samples, unspun, at room temperature.
Use Diagnostic Specimen packs and **FIRST OVERNIGHT PRIORITY SHIPPING** to ensure timely delivery.
The lab operates M-F only. Closed Saturday and Sunday.

Please call with the courier and tracking number of the package.

PATIENT & SAMPLE INFORMATION

Patient Name	Patient Identification Number	Date of Sample	Time of Sample
Date of Birth	Gender: ☐Male ☐ Female	Has the patient undergone BMT? ☐ No ☐ Yes – date of BMT _____	
Diagnosis or reason for testing			Diagnosis Code

Race: ☐ African-American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other (specify) _____

Medications:

TESTS REQUESTED

- ☐ ALPS Panel 3ml (1ml) EDTA **CBC/Diff**[3]
- ☐ Antigen Stimulation 10ml (5ml) Sodium Heparin[1]
- ☐ Apoptosis (Fas-mediated) 20ml (10ml) ACD-A
  Note: Sample must be <24 hrs old and received Thursday AM
- ☐ B Cell Panel [2] 3ml (1ml) EDTA **CBC/Diff**[3]
- ☐ BAFF, Plasma Levels 3ml (1ml) EDTA
- ☐ CD40L / ICOS 5ml (3ml) Sodium Heparin
- ☐ CD45RA/RO*NEW REVISED PANEL* 3ml (1ml) EDTA
- ☐ CD52 Expression[2] 3ml (1ml) EDTA
- ☐ CD64 (Leuko64) 1ml (0.5ml) EDTA
- ☐ CD107a Mobilization 10ml (5ml) Sodium Heparin[1]
  Note: CD107a is a 2 day test and cannot be accepted on Fridays
- ☐ CD127 / CD132 3ml (1ml) EDTA **CBC/Diff**[3]
- ☐ CTL Function 10ml (5ml) Sodium Heparin[1]
- ☐ Cytokines, Intracellular 3ml (2ml) Sodium Heparin
- ☐ Cytokines, Plasma 5ml (3ml) EDTA
- ☐ EBV Immortalized Cell Line 3ml Sodium Heparin
  - ☐ Check here if this is a research sample; signed consent required
- ☐ EDN (Eosinophil-Derived Neurotoxin) 3ml (1ml) EDTA
- ☐ Eotaxin-3 3ml (1ml) EDTA
- ☐ Foxp3 3ml (1ml) EDTA **CBC/Diff**[3]
- ☐ iNKT 3ml (1ml) EDTA
- ☐ Lymphocyte Activation Markers 3ml (2ml) Sodium Heparin
- ☐ Lymphocyte Subsets 3ml (1ml) EDTA
- ☐ MHC Class I & II 3ml (1ml) EDTA
- ☐ Mitogen Stimulation 10ml (5ml) Sodium Heparin[1]
- ☐ Neopterin 3ml (1ml) EDTA, or CSF[4]
- ☐ Neutrophil Adhesion Markers(CD18/CD11b) 3ml (1ml) EDTA
- ☐ Neutrophil Oxidative Burst 3ml (1ml) EDTA
- ☐ NK Function[2] 10ml (5ml) Sodium Heparin[1]
- ☐ Perforin/Granzyme B 3ml (1ml) EDTA
- ☐ PNH Screen (FLAER/CD59) 3ml (1ml) EDTA
- ☐ pSTAT5 3ml (1ml) EDTA
- ☐ SAP (XLP1) 3ml (1ml) Sodium Heparin
- ☐ Soluble CD163 2ml (1ml) EDTA
- ☐ Soluble IL-2R 3ml (1ml) EDTA
- ☐ Sorted Engraftment call to schedule
- ☐ TCR α/β / TCR γ/δ 3ml (1ml) EDTA
- ☐ TCR V beta Repertoire 3ml (2ml) EDTA
- ☐ WASP 3ml (1ml) Sodium Heparin
- ☐ WASP Transplant Monitor 3ml (1ml) Sodium Heparin
- ☐ XIAP (XLP2) 3ml (1ml) EDTA
- ☐ ZAP-70 (only for SCID) 3ml (1ml) EDTA
- ☐ Other _____

Notes:
1. Volumes requested assume a normal absolute lymphocyte count (ALC). If the ALC is abnormal, please call the lab for adjusted volume requirements when ordering any of the following tests: Antigen Stimulation, Mitogen Stimulation, CTL Function, NK Function, or CD107a Mobilization.
2. It is strongly recommended that a Lymphocyte Subset also be ordered when ordering a B Cell Panel, CD52, or NK Function.
3. Results of a same day CBC/Diff must accompany the sample where indicated.
4. Neopterin CSF samples should be shipped at 2-8℃. Neopterin EDTA samples should be shipped at room temperature.

REFERRING PHYSICIAN INFORMATION

Physician Name (print): _____ Email: _____

Phone: (_____) _____ Fax: (_____) _____

PHYSICIAN SIGNATURE (REQUIRED): _____ **DATE:** _____

****BOTH PAGES OF REQUISITION MUST BE COMPLETED. INCOMPLETE FORMS MAY RESULT IN THE COMPROMISE OF THE SPECIMEN'S INTEGRITY WHILE THE MISSING INFORMATION IS BEING OBTAINED****

Billing & Reporting Information

Patient Name:
DOB:

Diagnostic Immunology
Laboratory Billing Information

Cincinnati Children's Hospital
Medical Center

Cancer & Blood Diseases Institute

3333 Burnet Avenue
Cincinnati, OH
45229-3039

Phone: 513-636-4685
Fax: 513-636-3861
www.cincinnatichildrens.org/DIL
www.cincinnatichildrens.org/DCHI

Billing Information - Referring Institution or MD

The institution sending the sample is responsible for payment in full.
The Diagnostic Immunology Laboratory of CCHMC does not bill patients or their insurance.

Institution:
Address
City/State/Zip
Contact Name
Phone
Fax
Email

Reporting Information – Please provide reporting information

Name: Fax #:
Name: Fax #:

Laboratory Hours

The laboratory operates Monday through Friday, 8:00 am to 5:30 pm (Eastern Standard Time).
We cannot accept deliveries on Saturdays/Sundays and certain holidays.

Billing / Shipping / Handling

- **The institution sending the sample is responsible for payment in full.**
- Samples should be sent at room temperature, unless informed otherwise. Package securely to avoid breakage and extreme weather conditions. Please include a completed copy of our test requisition form with each sample. We recommend using a Diagnostic Specimen pack to ensure proper processing and timely delivery of samples to the lab.
- **Samples must be received in our laboratory within 24 hours of being drawn**. Plan the draw and shipping accordingly.
- Please call the laboratory with the name of the courier and the tracking number of the package.

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