Molecular and Genomic Pathology Services - Immunology

Division of Pathology • 513-636-9820
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****Samples will **not** be processed unless all information is provided and legible.****

PATIENT DEMOGRAPHICS

Patient Name: _____, _____ , __
Last First MI

Date of Birth: _____ / _____ / _____ Male Female

BILLING INFORMATION

Physician Name (print): _____

Diagnosis Code(s): _____

- ☐ Billing information attached - include a copy of insurance card/face sheet
- ☐ Bill patient
- ☐ Bill institution

Internal Use Only:
Client Code: _____
CCHMC MRN: _____
CSN: _____

SAMPLE INFORMATION

Specimen Type: Serum (1mL gold top [SST])

Collection Date: _____

Collection Time: _____

Note: please see test information sheet for collection information.

ORDERING PHYSICIAN

Physician Name (print): _____

Address: _____

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

_____ Date: ____/ _____/ _____
Referring Physician Signature (REQUIRED)

Comments:

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SHIPPING INFORMATION

Ship to:
Cincinnati Children's Hospital Medical Center
Attn: Molecular and Genomic Pathology Services (MGPS)
240 Albert Sabin Way, R2.001
Cincinnati, OH 45229

TEST(S) REQUESTED

- ☐ Anti-nuclear antibodies (ANA)
- ☐ Anti-dsDNA antibodies (dsDNA)
- ☐ Extractable nuclear antibodies (ENA)
  - ☐ SSa
  - ☐ SSb
  - ☐ RNP
  - ☐ Sm
  - ☐ Jo-1
- ☐ Autoantibody screen (also includes ANA)
  - ☐ Anti-liver/kidney microsomal antibodies (ALKMA)
  - ☐ Anti-mitochondrial antibodies (AMA)
  - ☐ Anti-parietal cell antibodies (APCA)
  - ☐ Anti-smooth muscle antibodies (ASMA)