



IMMUNOPATHOLOGY LABORATORY

Phone: 513.803.2567 • Fax: 513.803.2826
 Lab Hours: Monday – Friday 8:00 am – 5:00 pm EST
 www.cchmc.org/IPL

Ship First Overnight to:
CCHMC—CDBI Laboratories
 DIL—RM R2328
 3333 Burnet Ave.
 Cincinnati, OH 45229-3039

IPL – TEST REQUISITION FORM

ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED
 THIS FORM IS A FILLABLE PDF

Patient and Specimen Information

Patient Name (Last, First) _____, _____ Date of Birth: ____/____/____
 Patient Medical Record Number: _____ Date of Sample: ____/____/____ Collection Time: _____
 Gender: Male Female BMT? Yes No If Yes, then Date of BMT: _____ Relevant Medications: _____
 Dx or Reason for testing: _____ Sample Type: _____

TESTS OFFERED: MAX VOLUME LISTED IN THE PREFERRED SAMPLE VOLUME

Oncology Assays (Immunophenotyping)

When indicated, additional markers will be performed to help define the population of interest

Leukemia/Lymphoma Panel Technical component only – no interpretation	3 – 4 mL Bone Marrow or Peripheral Blood Sodium Heparin Green top or EDTA Lavender top, ambient
Minimal Residual Disease Testing for B-ALL (COG-approved) Day 8 Induction PB Day 29 Induction BM Other time point (specify): _____	3 – 4 mL Bone Marrow or Peripheral Blood Sodium Heparin Green top or EDTA Lavender top, ambient Please send copies of the original diagnosis flow report (dot plots) if possible. ***This test is not validated for specimens from patients currently receiving or have recently received any anti-B cell therapy. This includes CAR-T cell therapy, blinatumomab, etc. Please call the laboratory at 513-803-2567 with any questions prior to shipping specimens***
Tissue/Fluid Panel Source/type: _____ Technical component only – no interpretation	Store tissue in transport media (RPMI). Collect fluids in a sterile transport tube (2 – 5 mL if possible, please call the laboratory at 513-803-5816 for smaller volumes.) All tissue/fluid specimens should be shipped with a cold pack (not frozen or with dry ice)

Hematology Assays

HLA-B27 by Flow Cytometry	1 – 3 mL Peripheral Blood only EDTA Lavendar top, critical ambient, testing must occur with 72 hours of collection
PNH with CD59/FLAER (Paroxysmal Nocturnal Hemoglobinuria)	3 – 4 mL Peripheral Blood only EDTA Lavender top, ambient, testing must occur within 24 hours of collection
Neutrophil CD64 Expression	1 mL Peripheral Blood only EDTA Lavender top, shipped with a cold pack (not frozen or with dry ice), testing must occur within 48 hours of collection.

Additional instructions/comments regarding testing or reporting requests

REFERRING PHYSICIAN

Physician Name (print): _____
 Phone: (____) _____ Fax: (____) _____
 Email: _____
 Date: ____/____/____
 Referring Physician Signature _____

BILLING & REPORTING INFORMATION

We do not bill patients or their insurance. Please provide billing information here:
 Institution: _____
 Address: _____
 City/State/ZIP: _____
 Phone: (____) _____ Fax: (____) _____

ADDITIONAL INFORMATION:

Please see testing requirements for shipping instructions. Samples should not be shipped frozen or on dry ice. The lab operates Mon–Fri 8:00 am – 5:00pm (EST). Testing is not performed and samples cannot be received on weekends/certain holidays. A sample must be received by the laboratory by 3pm on Friday to guarantee that testing will be performed. First Overnight shipping is strongly recommended. Please call or fax the tracking number so that we may better track your specimen.

FOR LABORATORY USE ONLY	Received by: _____
--------------------------------	--------------------