



Molecular and Genomic Pathology Services - Immunology

Division of Pathology • 513-636-9820

pathology@cchmc.org • cincinnatichildrens.org/pathology

****Samples will **not** be processed unless all information is provided and legible.****

PATIENT DEMOGRAPHICS

Patient Name: _____, _____, _____ MI
Last First

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:

SHIPPING INFORMATION

Ship to:

Cincinnati Children's Hospital Medical Center
 Lab Processing, GL1.279
 Attn: Molecular and Genomic Pathology Services (MGPS)
 3333 Burnet Ave.
 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)