Cincinnati Children's
changing the outcome together

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 – Julie Beach
Rm R2328
3333 Burnet Avenue
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?** ☐ No ☐ Yes ☐ Unknown **If Yes, then Date of BMT:** _____ **Relevant Medications:** _____

Diagnosis/Reason for Testing: _____

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
☐ **CLL Panel** ☐ Technical component only	3-4 mL Bone Marrow or Peripheral Blood Sodium Heparin Green top or EDTA Lavender top, ambient
☐ **Plasma Cell Panel** ☐ Technical component only – no interpretation	3-4 mL Bone Marrow 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. ****The IPL is not validated to test 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

☐ **PNH with CD59/FLAER (Paroxysmal Nocturnal Hemoglobinuria)**	3-4 mL Peripheral Blood EDTA Lavender top, ambient
☐ **Neutrophil CD64 Expression**	1 mL Peripheral Blood EDTA Lavender top, refrigerated, testing must occur within 48 hours of collection.

Additional instructions/comments regarding testing or reporting requests

_____

_____

REFERRING PHYSICIAN

Physician Name (print): _____

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

Email: _____

_____ | _____ |
Referring Physician Signature **Date**

BILLING & REPORTING INFORMATION

We do not bill patients or their insurance. Please provide billing information here:

Institution: _____

Address: _____

City/State/ZIP: _____

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

Shipping/Specimen Instructions:
Please see testing requirements for shipping instructions. Samples should not be shipped frozen or on dry ice. Please call the IPL with any questions regarding these requirements.

Additional Information:
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.