

Patient's Last Name		First	Middle	Birth date (required)	Sex
Outside Patient Number	Outside Specimen Number		Send Report To		
Ordering Provider			Address		
Phone Number	Diagnosis/ICD Code		Phone/Fax		

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: ____/____/____ TIME COLLECTED: ____:____ PM

AM Serum Whole Blood

Other: _____

HEMATOPATHOLOGY/FLOW

- Lymphocyte Subset Analysis (T&B Cell)- T&B COMM ***
(Must complete boxed information below; attach CBC results with Differential if indicated)

<p>Lymphocyte Subset Analysis Panels: The minimum panel available includes CD3 and CD4</p> <p><input type="checkbox"/> CD3 and CD4 <input type="checkbox"/> CD4/CD8: CD3, CD4, CD8, T4/T8 ratio <input type="checkbox"/> CD3, CD4, CD8, and CD19, CD20, T4/T8 ratio <input type="checkbox"/> HIV Panel: CD2 and CD3, CD19, HLA-DR, CD4, CD8, T4/T8 ratio <input type="checkbox"/> Full Panel: CD2, CD3, HLA-DR, CD4, CD8, CD16 and CD56, CD19, T4/T8 ratio</p> <p>ADDITIONAL ANTIBODIES:</p> <p><input type="checkbox"/> CD20 (pan B-cell) <input type="checkbox"/> T cell receptor alpha-beta/gamma-delta <input type="checkbox"/> CD45RA RO <input type="checkbox"/> ALPS Screen <input type="checkbox"/> Leukocyte Adhesion Workup: CD11a, CD11b, CD11c, CD18</p>
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- Hereditary Spherocytosis Screen
 HLA B27
 Neutrophil Oxidative Burst*
 Anti Neutrophil Antibodies by Flow Cytometry > 4 months old
 Anti Neutrophil Antibodies by Flow Cytometry < 4 months old*
Requires special processing. Call Lab at (206) 987-2560 to schedule

Patient Name _____ DOB _____

Mother Name _____ DOB _____

Father Name _____ DOB _____

- Platelet Receptor Workup by Flow Cytometry (PLT RECPT)**
 Bernard-Soulier Platelet Characterization by Flow Cytometry
 Glanzmann Thrombasthenia Platelet Characterization by Flow Cytometry

- SCID Newborn Follow-up***
 B Cell Immunophenotyping*
(Switched/Unswitched Memory B cells & B Cell Developmental Subsets)

PERTINENT CLINICAL INFORMATION:

Suspected

Diagnosis: _____

Has patient had:

Bone Marrow Transplant Gene Therapy Date: _____

Pertinent History:

Lymphocyte Stimulation Studies

(Must indicate stimulants below)

- Antigen Stimulation Studies***
 Tetanus Toxoid Candida Antigen
 Mitogen Stimulation Studies*
 PHA CD3

IMMUNOLOGY/RHEUMATOLOGY

- | | | |
|--|--|--|
| <input type="checkbox"/> Anti Neutrophil Cytoplasmic Antibody Screen (ANCA) ** | <input type="checkbox"/> Anti Histone Antibody | <input type="checkbox"/> Anti SCL-70 |
| <input type="checkbox"/> Anti Myeloperoxidase Antibody | <input type="checkbox"/> Anti Jo-1 Antibody | <input type="checkbox"/> Anti Smooth Muscle Antibody |
| <input type="checkbox"/> Anti Proteinase 3 | <input type="checkbox"/> Anti Liver Kidney Microsomal Antibody | <input type="checkbox"/> ENA Panel (Anti SSA, Anti SSB, RNP, SM) |
| <input type="checkbox"/> Anti Centromere Antibody | <input type="checkbox"/> Anti Mitochondrial Antibody | |
| <input type="checkbox"/> Anti DNA Antibodies (dsDNA) | <input type="checkbox"/> Anti Nuclear Antibody Screen (ANA) ** | |

*SPECIAL PROCESSING INSTRUCTIONS: **Neutrophil Oxidative Burst/Mitogen/Antigen stimulation studies/Lymphocyte Subset Analysis/B Cell phenotyping:** It is critical that these samples be kept at room temperature; use extra packing if necessary to maintain temperature. Samples have limited stability. For updated specimen requirements and time limitations, see <http://seattlechildrenslab.testcatalog.org> and/or call the Cell Marker Lab at (206) 987-2560.

Anti Neutrophil Antibodies by Flow Cytometry <4 months old: Must contact lab for important information prior to drawing samples. Parent samples required in addition to child. For further information, see: <http://seattlechildrenslab.testcatalog.org>.

**REFLEXIVE TESTING POLICY AND DESCRIPTIONS: Reflexive testing is performed when initial test results are positive or outside normal parameters; or when specimen type/patient demographics warrant medically appropriate. Ordering providers reserve the right to order tests without the reflex option by indicating restrictions on the requisition.

~Anti Nuclear Antibody (ANA) Screen: Titer performed if screen is positive ~Anti Neutrophil Cytoplasmic Ab (ANCA) Screen: Titer performed if screen is positive.

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

- Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

- Primary Insurance** (Attach copy of card.) **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)	Employer	
Primary Care Physician	Phone Number	
Insurance Company/Medical Coverage		
Claims Address	Phone Number	
Policy Number	Group Number	
Subscriber	Sex	Subscriber's DOB

- Secondary Insurance** (Attach copy of card.) **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address	Phone Number	
Policy Number	Group Number	
Subscriber	Sex	Subscriber's DOB

- Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at <http://seattlechildrenslab.testcatalog.org> for testing information or call:
Lab Client Services (206) 987-2617 Cell Marker Lab (206) 987-2560



Ship to: LABORATORY
4800 Sand Point Way NE, M/S: OC.8.720
SEATTLE, WA 98105