

Test Requisition Form

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth: ____/____/____

Medical Record Number (MRN)*: _____ Date of Collection: ____/____/____ Time of Collection: _____

Gender: Male Female Relevant Medication: _____ Diagnosis or Reason for testing: _____

*If you do NOT have an MRN, please submit a client registration form below prior to submitting the first test order.

ORDERING PHYSICIAN

Name (print) _____ Phone: (____) _____ Fax: (____) _____

Email: _____ Physician Signature (Required): _____ Date: ____/____/____

Specimen Type:

- Peripheral Blood (PB)
- Bone Marrow (BM)
- Tissue (source) _____

Shipping Instruction:

Ship specimen at **room temperature** protected from heat or cold.
 Samples must be received within 24 hours of being drawn.
 Please call the lab with the name of the courier and the tracking number on the package.
 Include a completed copy of the test requisition form with each sample.
 The laboratory operates 7 days a week 7 AM to 5 PM (Eastern Standard Time).

Ship Specimen to:

Lab Control, Farley 719
 Boston Children's Hospital
 300 Longwood Avenue
 Boston, MA 02115
 Tel: 617-355-6351
 Fax: 617-730-0385

Requested Tests:

Immune System Status

- | | |
|---|--------------------------|
| <input type="checkbox"/> Acute Lymphoproliferative Syndrome (ALPS and $\gamma\delta$ T cells) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> B cell Number (Total B Lymphocyte Count) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> CD40 Ligand (CD154) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> Common Variable Immunodeficiency (CVID) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> IL-2 Receptor gamma Chain (CD132) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> Leukocyte Adhesion Deficiency 1 & 2 (LAD) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> Memory B cells (IgD vs CD27) | PB 3 ml (1 m) EDTA |
| <input type="checkbox"/> Memory T cells (CD45RA vs CCR7) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> Neutrophil Oxidative Burst (DHR) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> Recent Thymic Emigrants (RTE: CD45RA vs CD31) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> Regulatory T cells (Tregs: CD25 vs CD127) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> SCID panel (T/B subsets & Memory T cells) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> T/B Subsets (TBNK: Absolute Lymphocyte Counts) | PB 3 ml (1 ml) EDTA |
| <input type="checkbox"/> T cell Mitogen Proliferation (Con A, PHA, anti-CD3) | PB 6 ml (1 ml) NaHeparin |
| <input type="checkbox"/> T cell Antigen Proliferation (Tetanus, Candida) | PB 6 ml (1 ml) NaHeparin |

Immunophenotyping

- | | |
|--|--------------------|
| <input type="checkbox"/> Acute Myeloid Leukemia (AML) Panel | PB or BM 3 ml EDTA |
| <input type="checkbox"/> AML Minimal Residual Disease | PB or BM 3 ml EDTA |
| <input type="checkbox"/> B cell Acute Lymphoblastic Leukemia (B-ALL) Panel | PB or BM 3 ml EDTA |
| <input type="checkbox"/> B-ALL Minimal Residual Disease | PB or BM 3 ml EDTA |
| <input type="checkbox"/> Leukemia Cell Ploidy | PB or BM 3 ml EDTA |
| <input type="checkbox"/> Lymphoma Panel (4 or 7 color) | PB or BM 3 ml EDTA |
| <input type="checkbox"/> Myelodysplastic Syndrome (MDS) panel | PB or BM 3 ml EDTA |
| <input type="checkbox"/> T cell Acute Lymphoblastic Leukemia (T-ALL) Panel | PB or BM 3 ml EDTA |

PRIMARY CONTACT FOR BILLING (submitting invoices, obtaining POs, billing questions)

First Name _____ Last Name _____ Department: _____

Institution Name _____

Mailing Address _____

City _____ State _____ Zip Code _____ Time Zone _____

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