

TEST REQUISITION FORM

PATIENT INFORMATION (required)

Patient Name: \_\_\_\_\_  
 Patient ID/MRN: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
 Location: \_\_\_\_\_ Lab ID: \_\_\_\_\_  
 Collection Date: \_\_\_\_\_ Collection Time: \_\_\_\_\_  
 Clinical History: \_\_\_\_\_

INSTITUTION CONTACT (required for billing)

Sending Location/Institution: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 Physician signature/Date: \_\_\_\_\_  
 Physician Name (printed): \_\_\_\_\_

FLOW CYTOMETRY

TEST(S) REQUESTED:

CODE	DESCRIPTION
<input type="checkbox"/> CD34SC*	CD34 STEM CELL ENUMERATION
<input type="checkbox"/> CYTIBD	CYTOKINE-IBD

CODE	DESCRIPTION
<input type="checkbox"/> CYTAPO	CYTOTOXICITY/APOPTOSIS
<input type="checkbox"/> NEUOXB	NEUTROPHIL OXIDATIVE BURST
<input type="checkbox"/> TINTL	T CELL INTERLEUKIN PROLIFERATION
<input type="checkbox"/> TLREC	TOLL-LIKE RECEPTOR
<input type="checkbox"/> TMITO	T CELL MITOGEN PROLIFERATION

\* Test offered to CHW ONLY and should be stored at 2-6° C.

Tests listed below MUST be provided with same day CBC/Differential results:

**IMPORTANT!! Only ONE test below may be selected per specimen submission.**

<input type="checkbox"/> AT4	ABSOLUTE T4
<input type="checkbox"/> AILYMP	AUTO LYMPH PROLIF SYNDROME
<input type="checkbox"/> BTK	BRUTON'S TYROSINE KINASE
<input type="checkbox"/> CVID	COMMON VARIABLE IMMUNODEFICIENCY
<input type="checkbox"/> HIGHM	HYPER IGM
<input type="checkbox"/> PERGRA	PERFORIN GRANZYME
<input type="checkbox"/> MSMD	MENDELIAN SUSCEP TO MYCOBACT DISEASE

<input type="checkbox"/> PID1	PRIMARY IMMUNODEFICIENCY 1
<input type="checkbox"/> PID2	PRIMARY IMMUNODEFICIENCY 2
<input type="checkbox"/> TCACT	T CELL ACTIVATION
<input type="checkbox"/> THIL17	T HELPER IL17 **
<input type="checkbox"/> TREG	T REGULATORY-FOXP3
<input type="checkbox"/> XLP	X-LINKED LYMPH PROLIF SYNDROME

**NOTE: THIL17 NOT to be collected on patients < 1 year of age**

SPECIMEN DELIVERY ADDRESS

Send samples at ROOM TEMPERATURE by **first priority overnight** to:

Medical College of Wisconsin  
 Clinical Immunodiagnostic and Research Lab  
 MACC Fund Research Center, Room 5072  
 8701 Watertown Plank Road  
 Milwaukee, WI 53226

>Please call 414-955-4165 with tracking number PRIOR to shipping.

CLINICAL IMMUNODIAGNOSTIC LAB USE ONLY

Date Received: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Specimen Type:  PB  Other: \_\_\_\_\_ # of vials: \_\_\_\_\_

Anitcoagulant:  Sodium Heparin  Other: \_\_\_\_\_

Pre-Analytic Condition:  Satisfactory  Unsatisfactory Def Code: \_\_\_\_\_

Notes: \_\_\_\_\_

