Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

MULTIPLE LAB TEST REQUEST FORM FOR MAILED-IN SPECIMENS

Department of Laboratories
4800 Sand Point Way NE FB.2.441
Seattle, WA 98105 (206) 987-2617
http://seattlechildrenslab.testcatalog.org/

Patient's Last Name	First	Middle	Birth Date	Legal Sex	Gender Identity

Transplant Diagnosis:	Diagnosis/ ICD-10 code:	Transplant Date:

Donor Name/URD#	First	Middle	Donor Birth Date	Donor Legal Sex	Donor Gender Identity

INDICATIONS:

CHECK ALL THAT APPLY

- ☐ Monitoring post-transplant, day #_____
- ☐ Suspected graft versus host disease
- ☐ Suspected relapse of original disease
- ☐ Suspected graft failure/rejection
- ☐ Suspected PTLD
- ☐ Suspected Secondary Malignancy
- ☐ Other: _____

TRANSPLANT TYPE:

- ☐ Myeloablative Allo
- ☐ Reduced Intensity Allo
- ☐ Non-myeloablative Allo
- ☐ Auto
- ☐ Syngeneic
- Protocol # _____

☐ **BONE MARROW ASPIRATE ONLY**
☐ **Morphology -** Pathology performed at local Institution

☐ **UNILATERAL BONE MARROW ASPIRATE AND CORE BIOPSY**
☐ **BILATERAL BONE MARROW ASPIRATES AND CORE BIOPSIES**

Send to Seattle Children's Hospital Labs:

☐ **Morphology**: If same day/overnight shipping, send 1ml EDTA tube, aspirate smear slides, and core biopsy in formalin; if later, send slides/blocks
☐ **Chromosome analysis** (SCH Cytogenetics) (1-2ml Sodium Heparin tube)
☐ **FISH - Specify probe(s)** (SCH Cytogenetics) (1-2ml Sodium Heparin tube): _____

☐ **Send to SCH, who will send to UW Hematopathology/FHCC Lab OR ☐ Send directly to UW Hematopathology/FHCC Lab**

FLOW CYTOMETRY (1-2ml Sodium Heparin tube)
☐ **Immunophenotyping**
☐ **Immunophenotyping for suspected PTLD**
☐ **Other:** _____

UW MOLECULAR TESTING (1-2ml EDTA tube)
☐ **BCR/ABL**, Quantitative Check one: ☐ p190 ☐ p210
☐ **Other:** _____

☐ **Chimerism without cell sorting** (FHCC CIL/HLA Laboratory) (1-2ml Sodium Heparin tube):

☐ **Virology PCR** (UW Molecular Virology): ☐ CMV ☐ HSV ☐ HHV6 ☐ Parvo ☐ EBV ☐ Other _____

☐ **Other** (Specify Lab and Testing):

☐ PERIPHERAL BLOOD

Send to Seattle Children's Hospital Labs:

☐ **Chromosome analysis** (SCH Cytogenetics) (1-2ml Sodium Heparin tube)
☐ **FISH - Specify probe(s)** (SCH Cytogenetics) (1-2ml Sodium Heparin tube): _____

Send directly to UW Hematopathology

FLOW CYTOMETRY
☐ **Immunophenotyping**
☐ **Immunophenotyping for suspected PTLD**
☐ **Other:** _____

MOLECULAR TESTING (1-2ml EDTA tube)
☐ **BCR/ABL**, Quantitative Check one: ☐ p190 ☐ p210
☐ **Other:** _____

☐ **Chimerisms - Send directly to FHCC/CIL/HLA Laboratory. Please fill out next page for chimerism requisition testing**

☐ **Virology PCR** ☐ CMV ☐ HSV ☐ HHV6 ☐ Parvo ☐ EBV ☐ Other _____
Send directly to UW Molecular Virology

☐ **Other** (Specify Lab and Testing):

☐ OTHER SPECIMEN

Specify Tissue and Site: _____
☐ **Morphology**: slides/blocks for review (to SCH Pathology)
☐ **Other** *(specify tissue, site, testing and lab)*: _____

☐ **Morphology-** Pathology performed at local Institution
☐ **Fresh or Frozen Sample(s) requested:** To SCH Pathology

Contact: _____ **Phone number:** _____ **Fax number:** _____ **Date form completed:** _____

Ordering Provider Signature Required: _____

Ordering Physician: _____ **Was sample obtained during inpatient stay?** ☐ Yes ☐ No
NPI Code: _____ **MD St/Co:** _____
Date/time Sample Obtained: ____/____/____ ___:___ : ☐ AM ☐ PM

Fred Hutch Cancer Center

***To FHCC CIL / HLA Laboratory - Please bill submitting institution (not Seattle Children's Hospital)**

FHCC CIL/HLA Requisition

Patient's Last Name	First	Middle	Birth Date	Legal Sex	Gender Identity

Originating Hospital MRN	Accession/Instrument ID	Send Report To
Ordering Provider	Provider's NPI	Address
Provider's Pager Number	Diagnosis/ICD Code	Phone/Fax

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: ____/____/_____

TIME COLLECTED: _____:_____ AM / PM

☐ Peripheral Blood ☐ Hair Follicles

☐ Bone Marrow ☐ Other (Specify): _____

PATIENT STATUS AT DATE/TIME OF COLLECTION: ☐ Inpatient ☐ Outpatient

FHCC CIL / HLA LABORATORY

Collect 10.0 mL Whole Blood in Dark Green/Sodium Heparin (Min. 3.0 mL Whole Blood).

☐ Cell Sorting for Chimerism (Cells to be Sorted)

- ☐ CD3 ☐ CD33 ☐ CD56 ☐ CD19 ☐ CD14 ☐ Other: _____

☐ Chimerism Without Cell Sorting

☐ Chimerism Baseline Specimen

- ☐ Patient Baseline ☐ Donor Baseline

☐ Maternal Engraftment Testing

- ☐ Patient Baseline (Buccal Swabs)
- ☐ Maternal Baseline (Collect 10.0 mL Whole Blood in Dark Green/Sodium Heparin)
- ☐ Patient whole blood specimen for Maternal Engraftment testing (Collect 3.0 mL Whole Blood in Dark Green/Sodium Heparin [Min. 1.0 mL]).

☐ Confirm Identical Twin

- ☐ Patient whole blood specimen or buccal swabs.
- ☐ Twin's specimen: saliva, buccal swabs, or whole blood.

Ship specimen(s) to:

FHCC CIL/HLA Laboratory

188 E. Blaine St., Suite 250

Seattle, WA 98102

(206) 606-1139

Comments:

***To FHCC CIL / HLA Laboratory - Please bill submitting institution (not Seattle Children's Hospital)**