Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Pediatric Blood and Marrow Transplant Program
Seattle Children's Hospital
Tel. 206.987.2106
Fax. 206.985.3437

FAX COVER SHEET

Date:

To: FAX:

From: RE:

Pages including cover:

Dear ,

Per recommendation for the recommended chimerism testing, the following sample(s) are needed for test completion

- 5 mL peripheral blood in NaHeparin

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SHIPMENT INSTRUCTIONS

1. **Complete the attached form** - Patient Registration and Facility Information.
2. **Label each tube** with:
   - Patient's name
   - Patient's date of birth
   - Date and time specimen collected
   - Type of specimen (i.e., peripheral blood)
3. **Fill out requisition** (next page)
4. **Ship the package** containing specimen(s), Test Request Form and Patient Registration/Facility Information Form) by overnight courier service (FedEx, DHL, etc) directly to (do NOT send to Seattle Children's Hospital):

   FHCC CIL / HLA Laboratory
   188 E. Blaine St., Suite 250
   Seattle, WA 98102
   206-606-1139

Please Note:

Do not send specimens to arrive on weekends or government holidays. (Do not draw samples on Fridays)
Send samples at room temperature unless otherwise instructed.

In response to Medicare 2011 changes to the Medicare Physician Fee Schedule, any laboratory test that is paid by the Clinical Lab Fee Schedule requires the ordering physician or qualified nonphysician practitioner to sign the lab requisition as well as the physician order.

Shipment charges are the responsibility of the patient or the facility sending the package. Fred Hutch will bill the patient or his/her insurance directly for testing. Please contact our office by phone at 206-606-1139 indicating when we should expect the package to arrive or if you have any further questions.

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)**