



Patient's Last Name	First	Middle	Birth Date (Required)	Legal Sex	Gender Identity
Outside Patient Number	Outside Specimen Number	Send Report To			
Ordering Provider	Address				
Phone Number	Diagnosis/ICD Code (Required)	Phone/Fax			

**REQUIRED SPECIMEN INFORMATION:**

DATE COLLECTED: \_\_\_/\_\_\_/\_\_\_      TIME COLLECTED: \_\_\_:\_\_\_ PM       AM       Serum       Whole Blood  
 Other: \_\_\_\_\_

## HEMATOPATHOLOGY/FLOW

- Lymphocyte Subset Analysis (T&B Cell) (LAB3271) \***  
(Must complete boxed information below; attach CBC results with Differential if indicated)

<p style="text-align: center;">Lymphocyte Subset Analysis Panels: <i>The minimum panel available includes CD3 and CD4</i></p> <p><input type="checkbox"/> CD3 and CD4</p> <p><input type="checkbox"/> CD4/CD8: CD3, CD4, CD8, T4/T8 ratio</p> <p><input type="checkbox"/> CD3, CD4, CD8, and CD19, CD20, T4/T8 ratio</p> <p><input type="checkbox"/> HIV Panel: CD2 and CD3, CD19, HLA-DR, CD4, CD8, T4/T8 ratio</p> <p><input type="checkbox"/> Full Panel: CD2, CD3, HLA-DR, CD4, CD8, CD16 and CD56, CD19, T4/T8 ratio</p> <p style="text-align: center;">ADDITIONAL ANTIBODIES:</p> <p><input type="checkbox"/> CD20 (pan B-cell)</p> <p><input type="checkbox"/> T cell receptor alpha-beta/gamma-delta</p> <p><input type="checkbox"/> CD45 RA RO (also includes CD3, CD4, &amp; CD8)</p> <p><input type="checkbox"/> ALPS Screen</p> <p><input type="checkbox"/> Leukocyte Adhesion Workup: CD11a, CD11b, CD11c, CD18</p>
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- Flow Cytometry PB Malignancy Workup (LAB2850)**
- Hereditary Spherocytosis Screen (LAB3162)**
- HLA-B27 Antigen (LAB869)**
- Neutrophil Oxidative Burst (LAB3348) \***
- Platelet Receptor Workup by Flow Cytometry (LAB3389)**
- Bernard-Soulier Platelet Characterization by Flow Cytometry
- Glanzmann Thrombasthenia Platelet Characterization by Flow Cytometry
- Paroxysmal Nocturnal Hemoglobinuria (PNH) Workup (LAB3395)**
- Other:** \_\_\_\_\_

## Lymphocyte Stimulation Studies (Must indicate stimulants below)

- SCID Newborn Screen Follow-up Panel by Flow Cytometry (LAB3449) \***
- B Cell Phenotyping (LAB2827) \***  
(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:**
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- Antigen Stimulation Studies (LAB2806) \***
- Tetanus Toxoid       Candida Antigen
- Mitogen Stimulation Studies (LAB3317) \***
- PHA       CD3

## IMMUNOLOGY/RHEUMATOLOGY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> <b>Anti Nuclear Antibody Screen (ANA) (LAB147) **</b>          | <input type="checkbox"/> <b>Double-stranded DNA (dsDNA) Antibody (LAB2979)</b>      | <input type="checkbox"/> <b>Myeloperoxidase Antibodies (LAB2796)</b> |
| <input type="checkbox"/> <b>Anti-Neutrophil Cytoplasmic Antibody (ANCA) ** (LAB458)</b> | <input type="checkbox"/> <b>Extractable Nuclear Antigen (ENA) Group (LAB3028) *</b> | <input type="checkbox"/> <b>Proteinase 3 Antibodies (LAB2802)</b>    |
| <input type="checkbox"/> <b>Anti-Mitochondrial Antibody (AMA) (LAB513)</b>              | <b>* Includes: (Anti SSA, Anti SSB, Anti SM, Anti SM/RNP Anti RNP)</b>              | <input type="checkbox"/> <b>SCL 70 Antibodies (LAB3450)</b>          |
| <input type="checkbox"/> <b>Anti-Smooth Muscle Antibody (ASMA) (LAB826)</b>             | <input type="checkbox"/> <b>JO-1 Antibody (LAB3242)</b>                             |  |
| <input type="checkbox"/> <b>Centromere B Antibody (LAB2906)</b>                         | <input type="checkbox"/> <b>Liver Kidney Microsomal Antibody (LAB3255)</b>          |  |

\*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 <https://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: <https://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 at (206) 987-2617