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

Cell Markers Peripheral Blood Requisition

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: ☐ Serum ☐ Whole Blood

DATE COLLECTED: ____/____/_____ TIME COLLECTED: ____: ____ AM / PM ☐ Other:_____

PERIPHERAL BLOOD HEMATOPATHOLOGY/FLOW

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

Lymphocyte Subset Analysis Panels:
The minimum panel available includes CD3 and CD4.
If no panel is selected the Full Panel will be performed by default.

- ☐ CD3 and CD4
- ☐ CD4/CD8: CD3, CD4, CD8, T4/T8 ratio
- ☐ CD3, CD4, CD8, and CD19, CD20, T4/T8 ratio
- ☐ HIV Panel: CD2 and CD3, CD19, HLA-DR, CD4, CD8, T4/T8 ratio
- ☐ Full Panel: CD2, CD3, HLA-DR, CD4, CD8, CD16 and CD56, CD19, T4/T8 ratio

ADDITIONAL ANTIBODIES:

- ☐ CD20 (pan B-cell)
- ☐ T cell receptor alpha-beta/gamma-delta
- ☐ CD45 RA RO (also includes CD3, CD4, & CD8)
- ☐ ALPS Screen
- ☐ Leukocyte Adhesion Workup: CD11a, CD11b, CD11c, CD18

☐ **SCID Newborn Screen Follow-up Panel by Flow Cytometry (LAB3449) ***

☐ **B Cell Phenotyping (LAB2827) ***
(Switched/Unswitched Memory B cells & B cell Developmental Subsets)

☐ **Flow Cytometry PB Malignancy Workup (LAB2850)**

☐ **COG Day 8 B-ALL Peripheral Blood Workup (LAB2938)**

☐ **Paroxysmal Nocturnal Hemoglobinuria (PNH) Workup (LAB3395)**

☐ **Hereditary Spherocytosis Screen (LAB3162)**

☐ **HLA-B27 Antigen (LAB869)**

☐ **Neutrophil Oxidative Burst (LAB3348) ***

☐ **Platelet Receptor Workup by Flow Cytometry (LAB3389)**

☐ **Other:**

_____

Lymphocyte Stimulation Studies
(Must indicate stimulants below)

☐ **Antigen Stimulation Studies (LAB2806) ***
☐ Tetanus Toxoid ☐ Candida Antigen

☐ **Mitogen Stimulation Studies (LAB3317) ***
☐ PHA ☐ CD3

PERTINENT CLINICAL INFORMATION:

Suspected Diagnosis:_____

Has patient had:

☐ Bone Marrow Transplant ☐ Gene Therapy Date: _____

Pertinent History:

* 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.

** BONE MARROW HEMATOPATHOLOGY TESTING: please use the Bone Marrow & Malignancy Requisition which includes morphology, flow cytometry, and cytogenetics orders. see https://seattlechildrenslab.testcatalog.org/ and/or call the Cell Marker Lab at (206) 987-2560

*** 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.

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

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Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.2.441
SEATTLE, WA 98105