Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Cell Marker

Department of Laboratories
4800 Sand Point Way NE OC.8.720
Seattle, WA 98105 (206) 987-2102
http://seattlechildrenslab.testcatalog.org/

Patient's Last Name	First	Middle	Birth date (required)	Sex

Outside Patient Number	Outside Specimen Number	Send Report To
Ordering Provider		Address
Phone Number	Diagnosis/ICD Code	Phone/Fax

REQUIRED SPECIMEN INFORMATION:
DATE COLLECTED: ____/____/_____ TIME COLLECTED: ____:____ AM ☐ PM ☐
☐ Serum ☐ Whole Blood
☐ Other:_____

HEMATOPATHOLOGY/FLOW

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

Lymphocyte Subset Analysis Panels:
The minimum panel available includes CD3 and CD4
☐ 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
☐ CD45RA RO
☐ ALPS Screen
☐ Leukocyte Adhesion Workup: CD11a, CD11b, CD11c, CD18

☐ **SCID Newborn Follow-up***

☐ **B Cell Immunophenotyping***
(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:

☐ **Hereditary Spherocytosis Screen**
☐ **HLA B27**
☐ **Neutrophil Oxidative Burst***

☐ **Platelet Receptor Workup by Flow Cytometry (PLT RECPT)**
☐ Bernard-Soulier Platelet Characterization by Flow Cytometry
☐ Glanzmann Thrombasthenia Platelet Characterization by Flow Cytometry

Lymphocyte Stimulation Studies
(Must indicate stimulants below)

☐ **Antigen Stimulation Studies***
☐ Tetanus Toxoid ☐ Candida Antigen

☐ **Mitogen Stimulation Studies***
☐ PHA ☐ CD3

IMMUNOLOGY/RHEUMATOLOGY

☐ **Anti Neutrophil Cytoplasmic Antibody Screen (ANCA) ****
☐ **Anti Myeloperoxidase Antibody**
☐ **Anti Proteinase 3**
☐ **Anti Centromere Antibody**
☐ **Anti DNA Antibodies (dsDNA)**
☐ **Anti Histone Antibody**
☐ **Anti Jo-1 Antibody**
☐ **Anti Liver Kidney Microsomal Antibody**
☐ **Anti Mitochondrial Antibody**
☐ **Anti Nuclear Antibody Screen (ANA) ****
☐ **Anti SCL-70**
☐ **Anti Smooth Muscle Antibody**
☐ **ENA Panel (Anti SSA, Anti SSB, RNP, SM)**

*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 http://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: http://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 (206) 987-2617.

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Ship to: LABORATORY
4800 Sand Point Way NE, M/S: OC.8.720
SEATTLE, WA 98105