Cincinnati Children's
changing the outcome together

DIAGNOSTIC IMMUNOLOGY LABORATORY
Phone: 513-636-4685 • Fax: 513-636-3861
Lab Hours: Monday–Friday 8:00 AM – 5:00 PM EST
www.cincinnatichildrens.org/DIL • CBDILabs@cchmc.org

Ship First Overnight to:
CCHMC - Julie Beach
DIL - Rm R2328
3333 Burnet Avenue
Cincinnati, OH 45229-3039

DIL - TEST REQUISITION FORM

MUST BE RECEIVED MONDAY – FRIDAY WITHIN 1 DAY OF COLLECTION UNLESS OTHERWISE INDICATED

PATIENT INFORMATION

Patient Name (Last , First) _____ , _____ Date of Birth: _____/_____/_____

Patient Medical Record Number: _____ Date of Sample: _____/_____/_____ Time of Sample: _____

Gender: ☐ Male ☐ Female BMT: ☐ Yes – Date: _____/_____/_____ ☐ No ☐ Unknown Relevant Medications: _____

Diagnosis or reason for testing: _____

TESTS OFFERRED: MAX VOLUME LISTED IS THE PREFERRED WHOLE BLOOD VOLUME

☐ **Alemtuzumab Plasma Level**	2-3mL Sodium Heparin	☐ **MHC Class I & II**	1-3ml EDTA
☐ **ALPS Panel by Flow** *Need CBC/Diff result*	1-3ml EDTA – See #2 Below	☐ **Mitogen Stimulation**	See #1 Below
☐ **Antigen Stimulation**	See #1 Below	☐ **Neopterin, Plasma or CSF**	1-3ml EDTA or 0.5-1ml CSF See #3 or #4 below
☐ **Apoptosis (Fas, mediated)**	10-20ml ACD-A	☐ **Neutrophil Adhesion Mrkrs: CD18/11b**	1-3ml EDTA
Note: Only draw Apoptosis on Wednesday for Thursday delivery		☐ **Neutrophil Oxidative Burst (DHR)**	1-3ml EDTA
☐ **B Cell Panel** *Need CBC/Diff result*	1-3ml EDTA – See #2 Below	☐ **NK Function (STRICT 28 HOUR CUT-OFF)**	See #1 Below
☐ **BAFF**	1-3ml EDTA – See #4 Below	☐ **Perforin/Granzyme B**	1-3ml EDTA
☐ **CD40L / ICOS**	3-5ml Sodium Heparin	☐ **pSTAT5**	1-3ml EDTA
☐ **CD45RA/RO**	1-3ml EDTA	☐ **S100A8/A9 Heterodimer**	2 (0.3mL) Gold serum aliquots, frozen w/in 4 hours of collection
☐ **CD52 Expression**	1-3ml EDTA	☐ **S100A12**	2 (0.3mL) Gold serum aliquots, frozen w/in 4 hours of collection
☐ **CD107a Mobilization (NK Cell Degran)**	See #1 Below	☐ **SAP (XLP1)**	1-3ml Sodium Heparin
Note: Only draw CD107a Monday – Wednesday		☐ **Soluble CD163**	1-2ml EDTA - See #4 Below
☐ **CD127/CD132**	1-3ml EDTA	☐ **Soluble Fas-Ligand (sFasL)**	1-3ml EDTA/Red/Gold - See #4 Below
☐ **CTL Function**	See #1 below	☐ **Soluble IL-2R (Soluble CD25)**	1-3ml EDTA - See #4 Below
☐ **CXCL9**	2 (0.5ml) EDTA plasma aliquots, frozen w/in 8 hours of collection	☐ **T Cell Degranulation Assay**	See #1 Below
☐ **Cytokines, Intracellular**	2-3ml Sodium Heparin	**Note: Only draw T Cell Degran Monday – Wednesday**	
☐ **Cytokines, Plasma or CSF** – *Includes: IL-1b, 2, 4, 5, 6, 8, 10, IFN-g, TNF-a, and GM-CSF*	3-5ml EDTA or 0.5-1ml CSF See #3 or #4 below	☐ **TCR α/β TCR γ/δ**	1-3ml EDTA
☐ **Foxp3** *Need CBC/Diff result*	1-3ml EDTA – See #2 Below	☐ **TCR V Beta Repertoire**	2-3ml EDTA
☐ **GM-CSF Autoantibody (GMAb)**	1-3ml Red/Gold - See #4 below	☐ **Th-17 Enumeration**	2-3ml Sodium Heparin
☐ **GM-CSF Receptor Stimulation**	1-3ml Sodium Heparin	☐ **WASP**	1-3ml Sodium Heparin
☐ **iNKT**	1-3ml EDTA	☐ **WASP Transplant Monitor**	1-3ml Sodium Heparin
☐ **Interleukin–18 (IL-18)**	3ml Red/Gold - See #4 below	☐ **XIAP (XLP2)**	1-3ml EDTA
☐ **Lymphocyte Activation Markers**	2-3ml Sodium Heparin	☐ **ZAP-70 (only for SCID)**	1-3ml EDTA
☐ **Lymphocyte Subsets**	1-3ml EDTA	☐ **Other:** _____	

REFERRING PHYSICIAN

Physician Name (print): _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

_____ Date: _____/_____/_____

Referring Physician Signature

BILLING & REPORTING INFORMATION

We do not bill patients or their insurance. Provide billing information here or on page 2.

Institution: _____

Address: _____

City/State/ZIP: _____

Phone: (_____) _____ Fax: (_____) _____

1. 5-10ml Sodium Heparin blood per test should be adequate for most patients unless they are lymphopenic. If you have volume constraints or an absolute lymphocyte count (ALC) of <1.0 K/uL, please see the Customized Volume Sheet on our website (www.cchmc.org/DIL) or call for adjusted volume requirements for the following tests: Antigen Stimulation, Mitogen Stimulation, CTL Function, NK Function, CD107a, or T Cell Degran.
2. Results of a concurrent CBC/Diff must accompany ALPS Panel, B Cell Panel, or Foxp3. (Results will be used to calculate absolute cell counts)
3. CSF Samples: a) Fresh Specimens: Ship with frozen ice packs to keep at refrigeration temp (2-8°C/35-46°F) for receipt within 48 hours of collection.
b) Frozen Specimens: Freeze within 48 hours of collection. Ship samples frozen on dry ice.
4. Specimen Processing and Shipping Instructions **only** for tests marked with **"See #4"**.
a) Unspun whole blood: Ship as unspun whole blood at Room Temperature for receipt within 24 hours of collection
b) Spun Specimens: Spin and remove serum/plasma from cells within 24 hours of collection. Freeze separated plasma/serum immediately. Ship frozen on dry ice. Once separated from cells, the serum/plasma must stay frozen until received by the DIL. Thawed samples will be rejected.

Additional Information:
• The lab operates Mon-Fri 8:00 AM – 5:00 PM (EST). ***Testing is not performed and samples cannot be received on weekends/certain holidays.***
• Samples should be sent as whole blood at room temperature and received in our laboratory within 1 day of collection, unless otherwise indicated.
• First Overnight shipping is strongly recommended. Please call or fax the tracking number so that we may better track your specimen.

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Patient Name: _____ Date of Birth: _____

ADDITIONAL BILLING INFORMATION – CONTINUED FROM PAGE 1

Institution: _____

Address: _____

City/State/ZIP: _____ Phone: (_____) _____ Fax: (_____)_____

Contact Name: _____

Phone: (_____) _____ Fax: (_____) _____ Email: _____

SEND ADDITIONAL REPORTS TO:

Name: _____ Name: _____

Fax Number: _____ Fax Number: _____

Laboratory Hours

The laboratory operates Monday through Friday, 8:00 AM to 5:00 PM (Eastern Standard Time). We cannot accept deliveries on Saturdays and Sundays and certain holidays.

Billing / Shipping / Handling

- The institution sending the sample is responsible for payment in full.
- Samples should be sent at room temperature unless otherwise indicated. Package securely to avoid breakage and extreme weather conditions. Please include a completed copy of our test requisition form with each sample. We recommend using a Diagnostic Specimen pack to ensure proper processing and timely delivery of samples to the lab.
- Samples must be received in our laboratory within 1 day of collection, unless otherwise indicated. Plan the draw and shipping accordingly. First Overnight is strongly recommended.
- Please call the laboratory or fax the information of the name of the courier and tracking number of the package.

Questions?

Please call 513-636-4685 with any questions regarding collection or billing.

****THE REQUISITION MUST BE FILLED OUT COMPLETELY. INCOMPLETE FORMS MAY RESULT IN THE COMPROMISE OF THE SPECIMEN INTEGRITY WHILE THE MISSING INFORMATION IS BEING OBTAINED****