NH Newborn Screening Program Referral for SCID Flow Cytometry

Instructions: Complete this form and send to Boston Children's Hospital with the specimen.

Ordered Procedure:SCID Newborn Flow Cytometry Panel

Specimen Type: 1-2cc whole blood in EDTA (purple top) tube.

Temperature: Specimens should be transported at room temperature.

Specimen Transport: MUST arrive at Boston Children's Hospital Flow Lab < 24 hours
Use FedEx PRIORITY OVERNIGHT or other similar high priority service.

SEND COMPLETED REFERRAL FORM TO BOSTON CHILDREN'S HOSPITAL WITH SPECIMEN
Call BCH Flow Lab to notify them to expect a specimen: 617-355-7620.

Ship to: Laboratory Control, Farley Building, 7th Floor
Boston Children's Hospital
300 Longwood Ave
Boston, MA 02115

Shipping questions: Ph: 617-355-6351
Technical questions: Ph:617-355-7620
Fax: 617-730-0385

PATIENT INFORMATION

Name ______________________ ☐ Male DOB ____________

Mother's name ______________________ ☐ Female

Address ______________________ Primary Phone Number ____________

City ______________ Zip code _____

INSURANCE INFORMATION

Insurance Name ______________________ Insurance Address ______________________

Policy # ______________________ ______________________

Policy Holder Name ______________________ Policy Holder DOB ______________________

PHYSICIAN INFORMATION

Ordering Physician Name: Phone: Fax:

Primary Care Physician Name ____

Ordering Physician Signature ____

SPECIMEN INFORMATION- **specimen must arrive with no more than 24 hours in transit.**

Date Sample Obtained: ___/___/______

Time Sample Obtained: ___/___/______

ORDERING DIAGNOSIS INFORMATION (ICD CODES REQUIRED)

[X] P09 ABNORMAL FINDINGS NEONATAL SCREEN

Attention CHB FLOW LAB: Fax a copy of results to :

[X] **NH Newborn Screening Program, Fax # 603 271-4519**