Clinical Flow Cytometry Laboratory
Department of Laboratory Medicine
Boston Children's Hospital
300 Longwood Avenue, Bader 773, Boston, MA, 02115
Phone: 617-355-7620 | Fax: 617-730-0383
ClinicalFlowCytometry@childrens.harvard.edu

Boston Children's Hospital
Until every child is well™

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Test Requisition Form

PATIENT INFORMATION

First Name _____ Last Name_____ Date of Birth: _____/_____/_____

Medical Record Number (MRN)*: _____ Date of Collection: _____/_____/_____ Time of Collection: _____

Gender: ☐ Male ☐ Female Relevant Medication: _____ Diagnosis or Reason for testing: _____

*If you do NOT have an MRN, please submit a client registration form below prior to submitting the first test order.

ORDERING PHYSICIAN

Name (print)_____ Phone: (_____)_____ Fax: (_____)_____

Email:_____ Physician Signature (Required): _____Date:_____/_____/_____

Specimen Type:

- ■ **Peripheral Blood (PB)**
- ☐ **Bone Marrow (BM)**
- ☐ **Tissue (source)_____**

Shipping Instruction:

Ship specimen at **room temperature** protected from heat or cold.
Samples must be received within 24 hours of being drawn.
Please call the lab with the name of the courier and the tracking number on the package.
Include a completed copy of the test requisition form with each sample.
The laboratory operates 7 days a week 7 AM to 5 PM (Eastern Standard Time).

Ship Specimen to:

Lab Control, Farley 719
Boston Children's Hospital
300 Longwood Avenue
Boston, MA 02115
Tel: 617-355-6351
Fax: 617-730-0385

Requested Tests:

	Immune System Status	
☐	**Acute Lymphoproliferative Syndrome (ALPS and γδ T cells)**	**PB 3 ml (1 ml) EDTA**
☐	**B cell Number (Total B Lymphocyte Count)**	**PB 3 ml (1 ml) EDTA**
☐	**CD40 Ligand (CD154)**	**PB 3 ml (1 ml) EDTA**
☐	**Common Variable Immunodeficiency (CVID)**	**PB 3 ml (1 ml) EDTA**
☐	**IL-2 Receptor gamma Chain (CD132)**	**PB 3 ml (1 ml) EDTA**
☐	**Leukocyte Adhesion Deficiency 1 &2 (LAD)**	**PB 3 ml (1 ml) EDTA**
☐	**Memory B cells (IgD vs CD27)**	**PB 3 ml (1 m) EDTA**
☐	**Memory T cells (CD45RA vs CCR7)**	**PB 3 ml (1 ml) EDTA**
☐	**Neutrophil Oxidative Burst (DHR)**	**PB 3 ml (1 ml) EDTA**
☐	**Recent Thymic Emigrants (RTE: CD45RA vs CD31)**	**PB 3 ml (1 ml) EDTA**
☐	**Regulatory T cells (Tregs: CD25 vs CD127)**	**PB 3 ml (1 ml) EDTA**
■	**SCID panel (T/B subsets & Memory T cells)**	**PB 3 ml (1 ml) EDTA**
☐	**T/B Subsets (TBNK: Absolute Lymphocyte Counts)**	**PB 3 ml (1 ml) EDTA**
☐	**T cell Mitogen Proliferation (Con A, PHA, anti-CD3)**	**PB 6 ml (1 ml) NaHeparin**
☐	**T cell Antigen Proliferation (Tetanus, Candida)**	**PB 6 ml (1 ml) NaHeparin**
	Immunophenotyping	
☐	**Acute Myeloid Leukemia (AML) Panel**	**PB or BM 3 ml EDTA**
☐	**AML Minimal Residual Disease**	**PB or BM 3 ml EDTA**
☐	**B cell Acute Lymphoblastic Leukemia (ALL) Panel**	**PB or BM 3 ml EDTA**
☐	**ALL Minimal Residual Disease**	**PB or BM 3 ml EDTA**
☐	**Leukemia Cell Ploidy**	**PB or BM 3 ml EDTA**
☐	**Lymphoma Panel (4 or 7 color)**	**PB or BM 3 ml EDTA**
☐	**Myelodysplastic Syndrome (MDS) panel**	**PB or BM 3 ml EDTA**
☐	**T cell Acute Lymphoblastic Leukemia Panel**	**PB or BM 3 ml EDTA**

PRIMARY CONTACT FOR BILLING (submitting invoices, obtaining POs, billing questions)

First Name _____ Last Name_____ Department: _____

Institution Name CL - Concord Hospital

Mailing Address Concord Hospital Laboratory, 250 Pleasant Street

City Concord State NH Zip Code _____ Time Zone _____

Phone: (603) 227-7050 Fax: (603) 2287345