TEST REQUISITION

Ocular Immunology Laboratory
Oregon Health & Science University
Biomedical Research Building, Room 253
3181 SW Sam Jackson Park Road
Portland, OR 97239, USA
503-418-2543 (Phone), 503-418-2541 (FAX)

WE DO NOT BILL INSURANCE, NOR TAKE PT CALLS

PATIENT INFORMATION

Patient Last Name_____ _____First Name_____

Date of Birth (Month/day/year)_____Gender _____

Date Collected_____ Received Date_____

Ocular Immunology Accession #_____

REFERRING LABORATORY /PHYSICIAN Name Mayo Medical Laboratories

Street: 3050 Superior Drive NW

City:Rochester St: MN Zip: 55901

Phone: 800-533-1710 Fax:507-538-5340

Referring Physician Name:

_____ IDC-9 Diagnosis Code

CLINICAL HISTORY AND FINDINGS (Complete the appropriate information below or include in an accompanying letter)

INSURANCE will not be billed

REQUIRED PRE-PAYMENT - Method:
Mayo Medical Laboratories
3050 Superior Drive NW
Rochester, MN 55901
Phone 1-800-533-1710

TEST REQUESTED

[ ] Western blot for anti-retinal antibodies (CAR, MAR, Autoimmune Retinopathy)

[ ] Western blot for anti-retinal antibodies in ocular fluids

[ ] Immunohistochemistry for anti-retinal antibodies (CAR, MAR, Autoimmune Retinopathy)

[ ] Western blot for anti-optic nerve antibodies (Optic Neuropathy)

[ ] Western blot for anti-optic nerve antibodies in CSF

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