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 (STICKER ALSO ACCEPTED)

Patient Name (Last, First, MI): _____, _____, _____ DOB (MM/DD/YYYY): _____/_____/_____

Medical Record #: _____ Collection Date (MM/DD/YYYY): _____/_____/_____ Time of Sample(HH:MM): _____

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

Diagnosis or reason for testing: _____

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

☐ **Alemtuzumab Plasma Level**	2-3mL Sodium Heparin
☐ **ALPS Panel by Flow** *Need CBC/Diff result*	1-3ml EDTA – See #2 on page 2
☐ **Antigen Stimulation**	See #1 Below
☐ **Apoptosis (Fas, mediated)**	10-20ml ACD-A
Note: Only draw Apoptosis on Wednesday for Thursday delivery	
☐ **B Cell Panel** *Need CBC/Diff result*	1-3ml EDTA – See #2 on page 2
☐ **BAFF**	1-3ml EDTA – See #4 on page 2
☐ **CD40L / CD40FP / ICOS**	3-5ml Sodium Heparin
☐ **CD45RA/RO**	1-3ml EDTA
☐ **CD52 Expression**	1-3ml EDTA
☐ **CD107a Mobilization (NK Cell Degran)**	See #1 on page 2
Note: Only draw CD107a Monday – Wednesday	
☐ **CTL Function**	See #1 on page 2
☐ **CXCL9**	2 (0.5ml) EDTA plasma aliquots, frozen w/in 8 hours of collection
☐ **Cytokines, Intracellular**	2-3ml Sodium Heparin
☐ **Cytokines (Circle One): 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 on page 2
If sending frozen, 2 (0.5mL) EDTA plasma aliquots frozen, preferred	
☐ **Foxp3** *Need CBC/Diff result*	1-3ml EDTA – See #2 on page 2
☐ **GM-CSF Autoantibody (GMAb)**	1-3ml Red/Gold - See #4 on page 2
☐ **GM-CSF Receptor Stimulation**	1-3ml Sodium Heparin
☐ **iNKT**	1-3ml EDTA
☐ **Interleukin–18 (IL-18)**	3ml Red/Gold - See #4 on page 2
If sending frozen, 2(0.3mL) red/gold serum aliquots frozen, preferred	
☐ **Lymphocyte Activation Markers**	2-3ml Sodium Heparin
☐ **Lymphocyte Subsets**	1-3ml EDTA
☐ **MHC Class I & II**	1-3ml EDTA

☐ **Mitogen Stimulation**	See #1 on page 2
☐ **Neopterin (Circle One): Plasma or CSF**	1-3ml EDTA or 0.5-1ml CSF See #3 or #4 on page 2
☐ **Neutrophil Adhesion Mrkrs: CD18/11b**	1-3ml EDTA
☐ **Neutrophil Oxidative Burst (DHR)**	1-3ml EDTA
☐ **NK Function (STRICT 28 HOUR CUT-OFF)**	See #1 on page 2
☐ **Perforin/Granzyme B**	1-3ml EDTA
☐ **pSTAT5**	1-3ml EDTA
☐ **S100A8/A9 Heterodimer**	2 (0.3mL) Gold serum aliquots, frozen w/in 4 hours of collection
☐ **S100A12**	2 (0.3mL) Gold serum aliquots, frozen w/in 4 hours of collection
☐ **SAP (XLP1)**	1-3ml Sodium Heparin
☐ **Soluble CD163**	1-2ml EDTA - See #4 on page 2
☐ **Soluble Fas-Ligand (sFasL)**	1-3ml EDTA/Red/Gold - See #4 on page 2
☐ **Soluble IL-2R (Soluble CD25)**	1-3ml EDTA - See #4 on page 2
☐ **TCR α/β TCR γ/δ**	1-3ml EDTA
☐ **T Cell Degranulation Assay**	See #1 on page 2
Note: Only draw T Cell Degran Monday – Wednesday	
☐ **TCR V Beta Repertoire**	2-3ml EDTA
☐ **Th-17 Enumeration**	2-3ml Sodium Heparin
☐ **WASP**	1-3ml Sodium Heparin
☐ **WASP Transplant Monitor**	1-3ml Sodium Heparin
☐ **XIAP (XLP2)**	1-3ml EDTA
☐ **ZAP-70 (only for SCID)**	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: (_____) _____

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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 Information

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: See test line for acceptable specimen types. Spin and remove test-required serum or plasma from cells within 24 hours of collection. Freeze the separated plasma or serum immediately. Two aliquots per test are preferred. Ship frozen on dry ice. Once separated from cells, the serum or plasma must stay frozen until received by the DIL. Thawed samples will be rejected.

Visit our Clinical Lab Index at www.testmenu.com/cincinnatichildrens for detailed processing and testing information.

Additional Shipping & Handling Information

- ***Testing is not performed and samples cannot be received on Saturdays/Sundays and 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. We recommend using a Diagnostic Specimen pack to ensure proper processing and timely delivery of samples to the lab.
- Call with any questions or help with minimizing collection requirements.
- Package securely to avoid breakage and extreme weather conditions.
- Include a completed copy of our test requisition form with each sample.
- First Overnight shipping is strongly recommended. Please call, email or fax the tracking number so that we may better track your specimen.

Billing Information

- The institution sending the sample is responsible for payment in full.
- We do not third-party bill patient insurance.

Laboratory Information

- Hours: Monday through Friday, 8:00 AM to 5:00 PM (Eastern Standard Time). Closed on Weekends and some major holidays.
- Phone: 513-636-4685
- Fax: 513-636-3861
- Email: CBDILabs@cchmc.org

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****