Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

Cell Marker Testing

Department of Laboratories
4800 Sand Point Way NE OC.8.720
Seattle, WA 98105 (206) 987-2102
www.seattlechildrens.org/labman

Seattle Children's Med. Records Number:	Seattle Children's Account Number:	Processed By:	Date:

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name	First	Middle	Birth date (required)	Sex

Outside Patient Number	Outside Specimen Number	Send Report To
Ordering Provider		Address:
Phone Number	DIAGNOSIS / ICD-9:	Phone/Fax:

IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY:

ALL SAMPLES WILL BE BILLED TO THE REFERRING INSTITUTION UNLESS COMPLETE BILLING AND DIAGNOSIS INFORMATION IS PROVIDED ON THE BACK OF THIS FORM. CONTACT SEATTLE CHILDREN'S LABORATORY CLIENT SERVICES FOR ADDITIONAL ASSISTANCE. (206) 987-2617

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: _____ / _____ / _____ TIME COLLECTED: _____ : _____ ☐ AM ☐ PM ☐ Serum ☐ Whole Blood ☐ Other _____

HEMATOPATHOLOGY/FLOW

☐ **Antigen Stimulation Studies*** requires special processing
- ☐ **Tetanus Toxoid** ☐ **Candida Antigen**

☐ **Mitogen Stimulation Study*** requires special processing
- ☐ **PHA** ☐ **CD3**

☐ **Neutrophil Oxidative Burst*** requires special processing

☐ **Anti Neutrophil Antibodies by Flow Cytometry > 4 months old**

☐ **Anti Neutrophil Antibodies by Flow Cytometry < 4 months old***

Requires special processing. Call Lab at (206) 987-2560 to schedule

Patient Name _____ **DOB** _____

Mother Name _____ **DOB** _____

Father Name _____ **DOB** _____

☐ **Hereditary Spherocytosis Screen**

☐ **HLA B27**

☐ **Lymphocyte Subset Analysis (T&B Cell) - T&B COMM**

(Attach CBC results with Differential & **complete boxed information below.**)

Lymphocyte Subset Analysis Panels:

The minimum panel available includes CD3 and CD4.

☐ HIV Panel: CD2 and CD3, CD19, HLA-DR, CD4, CD8, T4/T8 ratio

☐ CD4/CD8: CD3, CD4, CD8, T4/T8 ratio

☐ CD3 and CD4

☐ Full panel: CD2, CD3, HLA-DR, CD4, CD8, CD16 and CD56, CD19, T4/T8 ratio

☐ CD3, CD4, CD8 and CD19, CD20, T4/T8 ratio

ADDITIONAL ANTIBODIES:

☐ ALPS Screen

☐ CD20 (pan B cell)

☐ Leukocyte Adhesion Workup: CD11a, CD11b, CD11c, CD18

☐ T cell receptor alpha-beta/gamma-delta

☐ Other _____

IMMUNOLOGY/RHEUMATOLOGY

☐ **Anti Neutrophil Cytoplasmic Antibody Screen (ANCA) ****

☐ **Anti Myeloperoxidase Antibody**

☐ **Anti Proteinase 3**

☐ **Anti Centromere Antibody**

☐ **Anti DNA Antibodies (dsDNA)**

☐ **Anti Histone Antibody**

☐ **Anti Jo-1 Antibody**

☐ **Anti Liver Kidney Microsomal Antibody**

☐ **Anti Mitochondrial Antibody**

☐ **Anti Nuclear Antibody Screen (ANA) ****

☐ **Anti SCL-70**

☐ **Anti Smooth Muscle Antibody**

☐ **ENA Panel (Anti SSA, Anti SSB, RNP, SM)**

OTHER

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_____

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SPECIMEN REQUIREMENTS FOR TESTS PERFORMED BY SEATTLE CHILDREN'S ARE AVAILABLE AT www.seattlechildrens.org/labman

BILLING INFORMATION

ALL INFORMATION MUST BE COMPLETE

BILL TO: ☐ Referring Institution (Preferred) - Provide billing address if different from report address
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients)

☐ Insurance (attach front and back copy of card) ☐ DSHS (only Alaska, Idaho, Montana, and Washington accepted)

☐ Patient - please provide credit card information below or enclose a check

Patient Address		Patient Phone
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer

Insurance Company/Medical Coverage	
Claims Address	Phone Number
Policy Number	Group Number
Subscriber	Subscriber DOB

Primary Care Physician	Phone Number

Name on Credit Card	Amount of Payment	CVN
Card Number	Card Type	Expiration

*SPECIAL PROCESSING INSTRUCTIONS

Neutrophil Oxidative Burst/Mitogen/Antigen stimulation studies/Lymphocyte Subset Analysis:
It is critical that samples for any of these studies be kept at room temperature; use extra packing if necessary to maintain temperature. Samples have limited stability - for updated specimen requirements and time limitations, see: http://www.seattlechildrens.org/labman and/or call the Cell Marker Lab at (206) 987-2560.

Anti Neutrophil Antibodies by Flow Cytometry < 4 months old:
Must contact lab for important information prior to drawing samples. Parent samples required in addition to child. For further information, see: http://www.seattlechildrens.org/labman

**REFLEXIVE TESTING POLICY AND DESCRIPTIONS:

Reflexive testing is performed when initial test results are positive or outside normal parameters; or when specimen type/patient demographics warrant medically appropriate additional testing. Ordering providers reserve the right to order tests without the reflex option by indicating restrictions on the requisition.

~Anti Nuclear Antibody (ANA) Screen: Titer performed if screen is positive
~Anti Neutrophil Cytoplasmic Ab (ANCA) Screen: Titer performed if screen is positive

SEND SPECIMENS TO:

Laboratory OC.8.720
4800 Sand Point Way NE
Seattle, WA 98105