

# Immunology Diagnostic Laboratory

Director: Hans D. Ochs, MD / Co-Director: Troy R. Torgerson, MD PhD  
CLIA (Washington) Mol. Dx #50D0973014 / Flow Cytometry #50D1056266

1900 Ninth Avenue  
Mailstop: C9S-7  
Seattle, WA 98101-1304  
Phone: (206) 987-7442  
Fax: (206) 987-7310  
Email: [idl@seattlechildrens.org](mailto:idl@seattlechildrens.org)

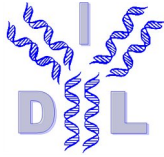
## SAMPLE SUBMISSION FORM

Patient Information:			Referring Physician Information:	
Last Name	First Name	MI	DOB	Physician Name
Street Address, City, State, Zip			Gender	Facility Name and Address
			<input type="checkbox"/> F <input type="checkbox"/> M	
Email			Ethnicity	Email
			<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish (Ashkenazi) <input type="checkbox"/> Other, Specify _____	
Home Phone	Work/Cell Phone		Phone	Fax

Institutional Billing Information:	
Hospital/Lab Name	<div style="border: 1px solid black; border-radius: 15px; padding: 20px; text-align: center;">INSTITUTIONAL BILLING ADDRESS STAMP</div>
Contact Name	
Street Address, City, State, Zip	
Phone	

Specimen Information:			
Test(s) Requested: (Please indicate on next page or list here)	Sample type: <input type="checkbox"/> Blood <input type="checkbox"/> Buccal swab <input type="checkbox"/> Skin fibroblasts <input type="checkbox"/> CVS/Ammiotic cells <input type="checkbox"/> Isolated DNA <input type="checkbox"/> Other, Specify _____	Date Sample Drawn:	Carrier Analysis or Prenatal Diagnosis: Indicate the index case, mutation, or include a copy of the mutation report.

Research Option:	
<p>If this box is checked, a member of the Ochs or Torgerson Labs may contact you after your genetic test is complete and the report is sent to offer you the opportunity to participate in an appropriate research project. For example, patients with negative results may have the opportunity to participate in projects designed to find new genes while patients with positive results may have the opportunity to participate in projects designed to correlate clinical finds with specific genetic changes. If there is not a research project that is appropriate for you at the time your report is complete, we will keep your name in our database and will contact you if a project becomes available in the future.</p>	
<input type="checkbox"/>	Yes, I am interested in learning about any research project that may pertain to me or my condition.
Patient Signature (if over 18 years old)	Date
Parent/Legal Guardian Signature (if patient under 18 years old)	Date



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## AVAILABLE TESTS

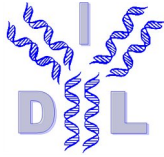
Patient Information:		
Last Name	First Name	MI

\*\* For information about **Bacteriophage ΦX174** neoantigen testing please contact the lab

### GENE SEQUENCING

### FLOW CYTOMETRY

<b>Common Variable Immunodeficiency (CVID)</b>			
<input type="checkbox"/> ICOS Gene	\$1000	<input type="checkbox"/> ICOS Protein Expression	\$450
<b>Hyper IgE Syndrome (HIES)</b>			
<input type="checkbox"/> STAT3 Gene	\$1150	<input type="checkbox"/> STAT3 Phosphorylation (IL-6 Stimulation)	\$500
<b>Hyper IgM Syndrome (HIGM)</b>			
<input type="checkbox"/> CD40 Ligand Gene	\$1000	<input type="checkbox"/> CD40 Ligand Protein Expression / CD40-Ig Binding	\$650
<input type="checkbox"/> CD40 Gene	\$1150	<input type="checkbox"/> CD40 Protein Expression	\$450
<input type="checkbox"/> AID Gene	\$1100	<input type="checkbox"/> Switched/Unswitched memory B cells	\$700
<input type="checkbox"/> UNG Gene	\$1150		
<b>Immune dysregulation, Polyendocrinopathy, Enteropathy, X-linked Syndrome (IPEX) / (IPEX-Like)</b>			
<input type="checkbox"/> FOXP3 Gene	\$1150	<input type="checkbox"/> FOXP3 Protein Expression/T <sub>REG</sub> Flow (Includes CD25 Protein Expression)	\$525
<input type="checkbox"/> CD25 Gene	\$1050		
<input type="checkbox"/> STAT5B Gene	\$1150		
<b>Leukocyte Adhesion Deficiency Type I (LADI)</b>			
<input type="checkbox"/> CD18 Gene	\$1250	<input type="checkbox"/> CD18 Protein Expression	\$500
<b>Netherton Syndrome</b>			
<input type="checkbox"/> SPINK5 Gene	\$1950	<input type="checkbox"/> SPINK5 Protein Expression (please call or email)	
<b>Severe Combined Immunodeficiency (SCID)</b>			
<input type="checkbox"/> IL2RG (Common Chain) Gene	\$1050	<input type="checkbox"/> STAT5B Phosphorylation (IL-2 Stimulation)	\$500
<input type="checkbox"/> JAK3 Gene	\$1450		
<input type="checkbox"/> RAG1/RAG2	\$1050		
<input type="checkbox"/> Artemis	\$1250		
<input type="checkbox"/> IL-7 Receptor α (CD127) Gene	\$1050	<input type="checkbox"/> CD127 Protein Expression	\$475
<input type="checkbox"/> ZAP-70 Gene	\$1050		
<b>Susceptibility to Mycobacterial Infections (Interferon-γ receptor, IL-12 receptor, or Tyk2 deficiency) Screening</b>			
		<input type="checkbox"/> STAT1/STAT4 Phosphorylation (IFN <sub>γ</sub> , IFN <sub>α</sub> , IL-12 Stimulation)	\$750
<b>Wiskott-Aldrich Syndrome (WAS)</b>			
<input type="checkbox"/> WASP Gene	\$1150	<input type="checkbox"/> WASP Protein Expression	\$450
<b>X-Linked Agammaglobulinemia (XLA)</b>			
<input type="checkbox"/> BTK Gene	\$1550	<input type="checkbox"/> BTK Protein Expression	\$500
<b>X-Linked Hypohydrotic Ectodermal Dysplasia with Immune Deficiency (EDA-ID)</b>			
<input type="checkbox"/> NEMO Gene	\$1150		
<input type="checkbox"/> IKBα Gene	\$1050		
<b>X-Linked Lymphoproliferative Disease (XLP)</b>			
<input type="checkbox"/> SAP (SH2D1A) Gene	\$950	<input type="checkbox"/> SAP Protein Expression	\$475
<input type="checkbox"/> XIAP (BIRC4) Gene	\$1050	<input type="checkbox"/> XIAP Protein Expression	\$475
<b>Immunophenotyping</b>			
<input type="checkbox"/> B Cell Immunophenotyping (Switched/Unswitched Memory B cells & B Cell Developmental Subsets)			\$700
<input type="checkbox"/> T Cell Immunophenotyping (CD4/CD8 Naïve, Effector, Effector Memory Subsets)			\$625
<input type="checkbox"/> Regulatory T cell Quantitation & Immunophenotyping			\$525
<b>Carrier Analysis / Family Member Analysis (known mutation) / Prenatal Diagnosis</b>			
<input type="checkbox"/> Carrier Analysis (known mutation)	\$450		
<input type="checkbox"/> Family Member Analysis (known mutation)	\$450		
<input type="checkbox"/> Prenatal Diagnosis (known mutation)	\$450		



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### SAMPLE REQUIREMENTS / SHIPPING INSTRUCTIONS

<b>Sample Requirements:</b>	Young Child:	DNA sequencing only	3-5cc
		Flow cytometry & sequencing	5-7cc
	Older Child/Adult:	DNA sequencing only	5-10cc
		Flow cytometry & sequencing	10-20cc

\*\*For any flow cytometry samples that are being shipped overnight please include a sample from a normal healthy individual as a control.

**Anticoagulant:** All samples should be collected in preservative-free sodium heparin anticoagulant. (Green-top Vacutainer® tubes work well).

**Packaging Instructions:** If needed, specimen packaging instructions are available as a pdf from FedEx: ([http://images.fedex.com/us/packaging/guides/UN3373\\_fxcom.pdf](http://images.fedex.com/us/packaging/guides/UN3373_fxcom.pdf))

**Shipping Instructions:**

- Ship at ambient temperature (DO NOT REFRIGERATE OR FREEZE)
- Ship via overnight courier (i.e.-- FedEx, UPS, Airborne Express, etc.)
- The lab accepts samples Monday-Friday but samples should be shipped only Monday-Thursday so they do not sit over the weekend.

**Shipping Address:** Immunology Diagnostic Laboratory  
Seattle Children's Research Institute  
1900 9<sup>th</sup> Ave., C9S-7  
Seattle, WA 98101-1304

**Please Include:** Patient Information – *Must be provided before test can be performed.*

- Patient's full name
- Patient contact information
- Date of birth and sex
- Attach any relevant clinical information that you feel is pertinent
- Ask patients to review the statement at the bottom of Sample Submission Form

Specimen Information – *Must be provided before test can be performed.*

- Sample type
- Tests requested
- Date sample collected
- Mutation information if sample is for Prenatal diagnosis or Carrier analysis

Reporting Information – *Reports are released only to individuals/institutions listed on the sample submission form.*

- Medical provider or institution to whom report should be sent
- Address to which paper report should be sent
- Telephone number of provider and/or institution
- Fax number of provider and/or institution
- Email address of provider listed above

Billing Information – *We do not bill insurance directly. The requesting institution will be billed unless other arrangements are made ahead of time.*

- Contact name and telephone for questions regarding billing