Cincinnati Children's
changing the outcome together

DIAGNOSTIC IMMUNOLOGY LABORATORY
Phone: 513-636-4685 • Fax: 513-636-3861
Lab Hours: Monday – Friday, 8 am – 5 pm EST
www.cincinnatichildrens.org/DIL • CBDILabs@cchmc.org

Ship First Overnight to:
CCHMC—CBDI Laboratories
DIL—RM R2328
3333 Burnet Ave., Cincinnati, OH 45229-3039

DIL — TEST REQUISITION FORM

Patient Information

MUST BE RECEIVED MONDAY – FRIDAY WITHIN 1 DAY OF COLLECTION UNLESS OTHERWISE INDICATED

Patient Name (Last, First) _____ , _____ Date of Birth: ____ / ____ / ____

Medical Record Number: _____ Collection Date: ____ / ____ / ____ Time of Sample: _____

Gender: ☐ Male ☐ Female Relevant Medications: _____

BMT: ☐ Yes — Date: ____ / ____ / ____ ☐ No ☐ Unknown Diagnosis/reason for testing: _____

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

☐ **Alemtuzumab Plasma Level**	2–3 mL Sodium Heparin See #5 on page 2
☐ **ALPS Panel by Flow Need CBC/Diff result**	1–3 ml EDTA, See #2 on page 2
☐ **Antigen Stimulation**	See #1 on page 2
☐ **Apoptosis (Fas, mediated)** *Note: Only draw Apoptosis on Wed. for Thurs. delivery*	10–20 mL Sodium Heparin
☐ **B Cell Panel**	1–3ml EDTA
☐ **BAFF**	1–3ml EDTA, See #4 on page 2
☐ **CD40L Expression / CD40-Ig Binding**	3–5ml Sodium Heparin
☐ **CD45RA/RO**	1–3ml EDTA
☐ **CD52 Expression**	1–3ml EDTA
☐ **CD107a Mobilization (NK Cell Degran)** *Note: Only draw CD107a Mon. – Wed.*	See #1 on page 2
☐ **CTL Function**	See #1 on page 2
☐ **CXCL9**	2 (0.3ml) EDTA plasma aliquots, frozen w/in 8 hours of collection
☐ **Cytokines (Circle One): Plasma or CSF** *Includes: IL-1b, 2, 4, 5, 6, 8, 10, IFN-g, TNF-a, and GM-CSF* If sending frozen, 2 (0.5ml) aliquots EDTA or CSF preferred	1–3ml EDTA or 0.5-1ml CSF See #3 or #4 on page 2
☐ **Foxp3** *Need CBC/Diff result*	1–3ml EDTA, See #2 on page 2
☐ **GM-CSF Autoantibody (GMAb)**	1-3ml Red/Gold preferred; EDTA or Sodium Heparin also acceptable
☐ **GM-CSF Receptor Stimulation**	1–3ml Sodium Heparin
☐ **iNKT**	1–3ml EDTA
☐ **Interleukin–6, CIA (IL-6 CIA)**	1–3ml EDTA, See #4 on page 2
☐ **Interleukin–18** *If sending frozen, 2(0.2mL) red/gold serum aliquots frozen, preferred*	1–3ml Red/Gold, See #4 on page 2
☐ **Interferon-alpha (IFN-alpha)**	1–3ml EDTA/Red/Gold, See #4 on page 2
☐ **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 (XLP-1) and XIAP (XLP-2)**	1–3ml Sodium Heparin
☐ **Soluble CD163**	1–3ml 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/ Red/Gold, See #4 on page 2
☐ **T Cell Degranulation Assay** *Note: Only draw T Cell Degran Mon. – Wed.*	See #1 on page 2
☐ **TCR α/β TCR γ/δ**	1–3mL of Sodium Heparin
☐ **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 Function** *Note: Only draw XIAP Function Mon–Wed*	6–10ml of Sodium Heparin
☐ **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: (____) _____

NOTE: PLEASE SEE IMPORTANT TEST REQUIREMENT INFORMATION ON PAGE 2.

FOR LABORATORY USE ONLY Received by: _____

Cincinnati Children's®
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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: _____

IMPORTANT TEST REQUIREMENT INFORMATION

1. Sodium Heparin blood is used for testing. Please review the Customized Volume Sheet on our website (www.cchmc.org/DIL) or call for adjusted volume requirements with an absolute lymphocyte count (ALC) of <1.0 K/uL. Tests affected: Antigen Stimulation, Mitogen Stimulation, CTL Function, NK Function, CD107a, and T Cell Degran.
2. Results of a concurrent CBC/Diff must accompany ALPS 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 (20–25° C) for receipt within **24 hours** of collection.
   b) Spun Specimens: Spin and remove serum/plasma from cells within **24 hours** of collection. Freeze separated plasma/serum immediately. Ship frozen on dry ice. Once separated from cells, the serum/plasma must stay frozen until received by the DIL. Thawed samples will be rejected.
5. Specimen Processing and Shipping Instructions **only** for tests marked with **"See #5"**:
   a) Unspun whole blood: Ship as unspun whole blood at Room Temperature (20–25° C) for receipt within **5 days** of collection. ***Chilled specimens will be rejected.***
   b) Spun Specimens: Spin at 2000 g for 10 minutes and remove test-required plasma from cells in 500 µL aliquots within 5 days of collection. Freeze separated plasma immediately. Two aliquots are preferred. Ship frozen on dry ice. Once separated from the cells, the plazma must remain frozen until recieved by the DIL.

Thawed samples will be rejected.

Additional Information

- Samples should be sent as whole blood at room temperature and received in our laboratory within 1 day of collection, unless otherwise indicated.
- First Overnight shipping is strongly recommended. Please call or fax the tracking number so that we may better track your specimen.

Laboratory Hours

- The laboratory operates Monday through Friday, 8 am – 5 pm (Eastern Standard Time). We cannot accept deliveries on Saturdays, Sundays, and certain holidays.
- Please refer to the Lab Test Directory (www.testmenu.com/cincinnatichildrens) for test-specific information including sample stability criteria and acceptable date/time arrival within operating hours.

Billing / Shipping / Handling

- The institution sending the sample is responsible for payment in full.
- Samples should be sent at room temperature unless otherwise indicated. Package securely to avoid breakage and extreme weather conditions. Please include a completed copy of our test requisition form with each sample. We recommend using a Diagnostic Specimen pack to ensure proper processing and timely delivery of samples to the lab.
- Samples must be received in our laboratory within 1 day of collection, unless otherwise indicated. Plan the draw and shipping accordingly. First Overnight is strongly recommended.

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****

Visit our Lab Test Directory at **www.testmenu.com/cincinnatichildrens** for detailed processing information.