Cincinnati Children's
changing the outcome together

IMMUNOPATHOLOGY LABORATORY
Phone: 513.803.2567 • Fax: 513.803.2826
Lab Hours: Monday – Friday 8:00 am – 5:00 pm EST
www.cchmc.org/IPL

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

IPL – TEST REQUISITION FORM

ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED
THIS FORM IS A FILLABLE PDF

Patient and Specimen Information

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

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

Gender: ☐ Male ☐ Female **BMT?** ☐ Yes ☐ No **If Yes, then Date of BMT:** _____ Relevant Medications: _____

Dx or Reason for testing: _____ Sample Type: _____

TESTS OFFERED: MAX VOLUME LISTED IN THE PREFERRED SAMPLE VOLUME

Oncology Assays (Immunophenotyping) *When indicated, additional markers will be performed to help define the population of interest*		
☐ Leukemia/Lymphoma Panel ☐ Technical component only – no interpretation	2903610	3 – 4 mL Bone Marrow or Peripheral Blood Sodium Heparin Green top or EDTA Lavender top, ambient
☐ Minimal Residual Disease Testing for B-ALL (COG-approved) ☐ Day 8 Induction PB ☐ Day 29 Induction BM ☐ Other time point (specify): _____	2903610	3 – 4 mL Bone Marrow or Peripheral Blood Sodium Heparin Green top or EDTA Lavender top, ambient Please send copies of the original diagnosis flow report (dot plots) if possible. ****This test is not validated for specimens from patients currently receiving or have recently received any anti-B cell therapy. This includes CAR-T cell therapy, blinatumomab, etc. Please call the laboratory at 513-803-2567 with any questions prior to shipping specimens****
☐ Tissue/Fluid Panel Source/type: _____ ☐ Technical component only – no interpretation	2903620	Store tissue in transport media (RPMI). Collect fluids in a sterile transport tube (2 – 5 mL); if possible, please call the laboratory at 513-803-5816 for smaller volumes.) All tissue/fluid specimens should be shipped with a cold pack (not frozen or with dry ice)
Hematology Assays		
☐ HLA-B27 by Flow Cytometry	LAB00673	1 – 3 mL Peripheral Blood only EDTA Lavendar top, critical ambient, testing must occur with 72 hours of collection
☐ PNH with CD59/FLAER (Paroxysmal Nocturnal Hemoglobinuria)	2902500	3 – 4 mL Peripheral Blood only EDTA Lavender top, ambient, testing must occur within 24 hours of collection
☐ Neutrophil CD64 Expression	2902200	1 mL Peripheral Blood only EDTA Lavender top, shipped with a cold pack (not frozen or with dry ice), testing must occur within 48 hours of collection.

Additional instructions/comments regarding testing or reporting requests

_____

_____

_____

REFERRING PHYSICIAN

Physician Name (print): _____

Phone: (____) _____ Fax: (____) _____

Email: _____

_____ Date: ____ / ____ / ____
Referring Physician Signature

BILLING & REPORTING INFORMATION

We do not bill patients or their insurance. Please provide billing information here:

Institution: _____

Address: _____

City/State/ZIP: _____

Phone: (____) _____ Fax: (____) _____

ADDITIONAL INFORMATION:

Please see testing requirements for shipping instructions. Samples should not be shipped frozen or on dry ice. The lab operates Mon–Fri 8 am – 5 pm (EST). Testing is not performed and samples cannot be received on weekends/certain holidays. A sample must be received by the laboratory by 3 pm on Friday to guarantee that testing will be performed. First Overnight shipping is strongly recommended. Please call or fax the tracking number so that we may better track your specimen.

FOR LABORATORY USE ONLY Received by: _____