MEDICAL COLLEGE OF WISCONSIN
Department of Pediatric
8701 Watertown Plank Road
Milwaukee, WI 53226

Website: www.mcw.edu/CIRL

CLINICAL IMMUNODIAGNOSTIC AND RESEARCH LAB
MACC Fund Research Center, Rm 5072
PHONE: 414-955-4165
FAX: 414-955-6487

A Jeffrey Modell Diagnostic Center for Primary Immunodeficiency

updated 2/2021

TEST REQUISITION FORM

PATIENT INFORMATION (required)

Patient Name: _____

Patient ID/MRN: _____

Date of Birth: _____ Sex: M _____ F _____

Location: _____ Lab ID: _____

Collection Date: _____ Collection Time: _____

Clinical History: _____

_____

INSTITUTION CONTACT (required for billing)

Sending Location/Institution:_____

Contact: _____

Address: _____

_____

FAX: _____ PHONE: _____

Physician signature/Date: _____

Physician Name (printed):_____

FLOW CYTOMETRY

TEST(S) REQUESTED:

	CODE	DESCRIPTION
☐	TMITO	T CELL MIOGEN PROLIFERATION
☐	CYTIBD	CYTOKINE-IBD
☐	TLREC/XIAP	TOLL-LIKE RECEPTOR
☐	CYTAPO	CYTOTOXICITY/APOPTOSIS
☐	NPF (former, NEUOXB)	NEUTROPHIL PHENOTYPE/FUNCTION
☐	TINTL	T CELL INTERLEUKIN PROLIFERATION

Tests listed *below* MUST be provided with same day CBC/Differential <u>results:</u>

IMPORTANT!! Only ONE test below may be selected per specimen submission.

☐	AT4	ABSOLUTE T4
☐	AILYMP	AUTO LYMPH PROLIF SYNDROME
☐	BTK	BRUTON'S TYROSINE KINASE
☐	CVID	COMMON VARIABLE IMMUNODEFICIENCY
☐	HIGM	HYPER IGM
☐	PERGRA	PERFORIN GRANZYME
☐	MSMD	MENDELIAN SUSCEP TO MYCOBACT DISEASE
☐	PID1	PRIMARY IMMUNODEFICIENCY 1
☐	PID2	PRIMARY IMMUNODEFICIENCY 2
☐	THIL17	T HELPER IL17**
		NOTE: THIL17 <u>NOT</u> to be collected on patients < 1 year of age
☐	TREG	T REGULATORY-FOXP3
☐	XLP	X-LINKED LYMPH PROLIF SYNDROME
☐	SGOF	STAT GAIN-OF-FUNCTION

SPECIMEN DELIVERY ADDRESS	**CLINICAL IMMUNODIAGNOSTIC LAB USE ONLY**
Send samples at ROOM TEMPERATURE by <u>FED EX First Overnight</u> to: Medical College of Wisconsin Clinical Immunodiagnostic and Research Lab MACC Fund Research Center, Room 5072 8701 Watertown Plank Road Milwaukee, WI 53226 ***>Please call 414-955-4165 with tracking number PRIOR to shipping.***	Date Received: _____ Time: _____ ☐AM ☐PM Specimen Type: ☐ *PB* ☐ *Other:* _____ # of vials: _____ Anitcoagulant: ☐ *Sodium Heparin* ☐ *Other:* _____ Pre-Analytic Condition: ☐ Satisfactory ☐ Unsatisfactory *Def Code:* _____ Notes: _____