ROSALIND FRANKLIN UNIVERSITY of MEDICINE AND SCIENCE

# Clinical Immunology Laboratory Requisition Form

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## PLEASE PRINT REFERRING PHYSICIAN

| NAME | | ADDRESS | CITY/STATE |
|---|---|---|---|
| NPI# | E-MAIL | PHONE | FAX |

## PATIENT INFORMATION: (Highlighted section MUST be completely filled out)

| LAST NAME | FIRST NAME | | PATIENT PHONE # |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |
| DATE OF BIRTH | ☐ MALE ☐ FEMALE | E-MAIL | COLLECTION DATE | TIME | ☐ AM ☐ PM |

## PAYMENT OR INSURANCE INFORMATION

**Billing:** ☐ **Client** ☐ **Patient** ☐ **Insurance**

☐ **CHECK HERE FOR NEW INSURANCE (INCLUDE LEGIBLE FRONT & BACK COPY OF INSURANCE CARD)**

**I hereby authorize Rosalind Franklin University to debit my credit card** ☐Visa ☐Master Card ☐Discover ☐American Express

Card Number:_____ Expiration Date_____ Security Code_____

Signature_____

Check Number_____ is enclosed **A $25.00 fee will be charged for returned checks.**

Financial Counselor: Email: CILBilling@rosalindfranklin.edu or phone 847-578-8815

We will bill as a courtesy to you. You are responsible for all non-covered service, co-insurance, copays and deductibles.

NAME OF INSURANCE _____

INSURANCE ID# _____ NAME OF INSURED _____

GROUP # _____ ADDRESS OF INSURANCE _____

RELATIONSHIP TO INSURED ☐ SPOUSE ☐ DEPENDENT ☐ SELF

**DIAGNOSIS CODE(S):** _____ : _____ : _____ : _____ : _____ INSURANCE PHONE #

## SERUM IMMUNOGLOBULINS and AUTO-ANTIBODIES

- ☐ Immunoglobulin Panel (IgG, IgM, IgA)
- ☐ Anti-phospholipid Antibodies (IgG, IgM, IgA)
- ☐ Anti-phospholipid Antibody Limited (IgG, IgM)
- ☐ Anti-DNA Antibodies (dsDNA, ssDNA, histones, Scl-70)
- ☐ Anti-nuclear Antibodies (ANA screen)
- ☐ Anti-thyroid Antibodies (thyroid peroxidase, thyroglobulin)
- ☐ Anti-ENA (anti-SM, RNP, SS/A and SS/B)
- ☐ Anti-β2 Glycoprotein I Antibodies

## TISSUE TYPING

- ☐ HLA-A, -B, -C Alleles
- ☐ HLA-DR Alleles
- ☐ HLA-DQα1 Alleles
- ☐ HLA-DQβ1 Alleles
- ☐ HLA-C Group
- ☐ KIR Genotyping

## CELLULAR ASSAYS by FLOW CYTOMETRY

- ☐ NK Assay, Panel
- ☐ NK Assay, Follow-up Panel
- ☐ NK Cell Inhibition Panel
- ☐ NK Assay with Prednisolone (MUST be ordered with ONE of the above NK Panels)
- ☐ Reproductive Immunophenotype
- ☐ T Regulatory Cell Levels
- ☐ $T_H1/T_H2$ Intracellular Cytokine Ratio
- ☐ $T_H1/T_H2$ Intracellular Cytokine Ratio, **IVIG**
- ☐ $T_H1/T_H2$ Intracellular Cytokine Ratio, **Prednisolone**
- ☐ $T_H1/T_H2$ Intracellular Cytokine Ratio, **IVIG & Prednisolone**
- ☐ $T_H17$ Intracellular Cytokine Levels
- ☐ Leukocyte Antibody Detection Panel (LAD)

Please fill in: (for LAD only).

## ENDOMETRIAL BIOPSY ASSAYS

- ☐ Endometrial Immune Profile
- ☐ Human Herpesvirus-6 (HHV-6)
- ☐ Decidualization Score, RNA Sequencing

## MOLECULAR TESTS

- ☐ Factor V Leiden Gene Polymorphism
- ☐ Factor V H1299R Gene Polymorphism
- ☐ MTHFR C677T Gene Polymorphism
- ☐ MTHFR A1298C Gene Polymorphism
- ☐ Prothrombin Gene Polymorphism
- ☐ Factor XIII Gene Polymorphism
- ☐ PAI-1 Gene Polymorphism
- ☐ β-Fibrinogen Gene Polymorphism
- ☐ HPA-1a/b Gene Polymorphism

Original: Lab

Copy: Client

(LAD) Partner:_____ Sex:_____ DOB:_____ Draw Date:_____