ROSALIND FRANKLIN UNIVERSITY of MEDICINE AND SCIENCE

Clinical Immunology Laboratory Requisition Form

Website: rfuclinlab.net

3333 Green Bay Road
Innovation & Research Park
North Chicago, IL 60064
Phone: 847-578-3444
Fax: 847-775-6506
E-mail: clinlab@rosalindfranklin.edu

REFERRING PHYSICIAN

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

Patient Information ***Patient / responsible party is financially / responsible for any portion of the claim not covered by insurance within 30 days***

Patient Name: _____ Patient Date of Birth: ____/____/____ Sex ❑ Male ❑ Female

Draw Date: _____ Draw Time: _____

Maling Address: _____ City: _____ State: _____ County (required for NY): _____ Zip: _____

Contact Information: Phone (____) _____ Email: _____

Responsible Party Name: _____

Responsible Party Date of Birth: ____/____/____ Responsible to Patient: ❑Self ❑Spouse ❑Partent ❑Other _____

❑ Same as patient.

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient/Responsible Party Signature: I authorize and request payment of medical benefits be made directly to Doctor's Data, Inc. I authorize the release of any medical information necessary to process this claim, I agree to be personally and fully responsible for any portion of the claim not covered by my insurance carrier and agree to make such payment within 30 days. A service charge of 1.5% per month may be charged on balances over 30 days.

X *(Required)* _____ Date: _____

INSURANCE INFORMATION

BILLING: ☐ CLIENT ☐ PATIENT ☐ INSURANCE ☐ CHECK THIS BOX FOR NEW INSURANCE (INCLUDE FRONT/BACK COPIES OF INSURANCE CARD)

NAME OF INSURANCE

INSURANCE # _____ GROUP # _____

ADDRESS OF INSURANCE

INSURANCE PHONE

Financial Counselor email: CILBilling@rosalindfranklin.edu , phone: 847-578-8815.

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

SERUM IMMUNOGLOBULINS and AUTO-ANTIBODIES

Diagnosis Codes(s) _____:_____:____

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

TISSUE TYPING

Diagnosis Codes(s) _____:_____:____

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

CELLULAR ASSAYS by FLOW CYTOMETRY

Diagnosis Codes(s) _____:_____:____

- ☐ 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)

ENDOMETRIAL BIOPSY ASSAYS

Diagnosis Codes(s) _____:_____:____

- ☐ Decidualization Score, RNA Sequencing

MOLECULAR TESTS

Diagnosis Codes(s) _____:_____:____

- ☐ 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

Please fill in: (for LAD only).

Original: Lab

Copy: Client

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

Ref No: G465956982