MEDICAL COLLEGE OF WISCONSIN
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A Jeffrey Modell Diagnostic Center for Primary Immunodeficiency

updated: 7/2019

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
CYTAPO	CYTOTOXICITY/APOPTOSIS
NPF (prior, NEUOXB)	NEUTROPHIL PHENOTYPE/FUNCTION
TINTL	T CELL INTERLEUKIN PROLIFERATION
TLREC/XIAP	TOLL-LIKE RECEPTOR

Tests listed MUST be provided with same day CBC/Differential results:

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

CODE	DESCRIPTION
AT4	ABSOLUTE T4
AILYMP	AUTO LYMPH PROLIF SYNDROME
PID1	PRIMARY IMMUNODEFICIENCY 1
PID2	