AMERIMMUNE

DIAGNOSTIC IMMUNOLOGY LABORATORY, A DIVISION OF O & O ALPAN

CLIA # : 49D2016663, Phone: 571-308-1900, Fax: 571-308-1919

Test Requisition Form

Samples must be **received** within 24 hours of being drawn. Send using
FIRST OVERNIGHT PRIORITY SHIPPING to:
Amerimmune
11212 Waples Mill Road, Suite 100, Fairfax VA 22030
Lab open Monday to Saturday.
For Courier pick-up call: (571) 308-1900

PATIENT INFORMATION (REQUIRED)

Patient Name: _____ **Date of Birth** _____ **Sex:** ☐ **Male** ☐ **Female**

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American

Diagnosis or reason for testing: _____ ICD9 code: _____

Brief History and Medications: _____

LABORATORY/ACCOUNT INFORMATION (REQUIRED):

Date Collected: _____ **Time Collected:** _____ ☐ **AM** ☐ **PM**

Sample Drawn At: ☐ **Hospital Inpatient** ☐ **Hospital Outpatient** ☐ **Physician Office**
☐ **Other** _____

Please draw a CBC with differential count with all samples and fax results to:
AMERIMMUNE, (571)308-1919
REPORT WILL NOT BE RELEASED WITHOUT THESE RESULTS

BILLING INFORMATION (REQUIRED)

PBILL TO: ☐ **Account** _____ ☐ **Insurance** ☐ **Laboratory** ☐ **Patient**

Amerimmune will bill patients insurance based on the information provided below. If billing information is not provided, the referring institution is responsible for payment in full. Certain insurances will not allow Amerimmune to bill insurance directly. In such cases, the referring institution is responsible for the payment.

I certify that the ordered test(s) is(are) reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

_____
Ordering Physician's Name Date Signature

PRIMARY INSURANCE: (Please attach a copy of insurance card, front and back)

Name of Policy Holder: _____

Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Phone: _____ Relation to Patient: _____

PHYSICIAN/INSTITUTION REFERRING/REPORTING INFORMATION (REQUIRED)

Name / NPI#: _____

Address: _____

_____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____

TEST REQUIRED

Lymphocyte Phenotyping

- ☐ B Cell subsets (Mature B and Plasma cell markers) _____ (2ml) EDTA
- ☐ B cell Maturation Evaluation (B cell development in peripheral blood) _____ (2ml) EDTA
- ☐ Lymphocyte subsets (T cell subsets, B cells and NK cells) _____ (2ml) EDTA
- ☐ Lymphocyte monitoring _____ (2ml) EDTA
  (T cell subsets, B and NK cells, γδ, αβ T-cells, NKT cells and activation markers)
- ☐ Memory CD8 and CD4 cells (CD45RO) _____ (2ml) EDTA

Eosinophil Phenotyping

- ☐ Hyper-eosinophilia Panel (CD69, CXCR3) _____ (2ml) EDTA

Other

- ☐ _____ (2ml) EDTA
- ☐ _____ (2ml) EDTA

AMERIMMUNE USE ONLY

Date Received: _____ **Time received:** _____ ☐ **AM** ☐ **PM**

Accession # _____ **By:** _____