MEDICAL COLLEGE OF WISCONSIN
Department of Pediatric
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Children's Hospital and Health System™ Children's Specialty Group™ MEDICAL COLLEGE OF WISCONSIN

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

Website: www.mcw.edu/CIRL

A Jeffrey Modell Diagnostic Center for Primary Immunodeficiency

updated: 1/2024

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
☐	FAHJB	FUNCTIONAL ASPLENIA/HOWELL-JOLLY BODY DETECTION
☐	PHOX	NADPH OXIDASE COMPLEX
☐	CYTAPO***	CYTOTOXICITY/APOPTOSIS
☐	NPF (prior, NEUOXB)	NEUTROPHIL PHENOTYPE/FUNCTION
☐	TINTL	T CELL INTERLEUKIN PROLIFERATION

Tests listed *below* 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
☐	BTK	BRUTON'S TYROSINE KINASE
☐	CVID	COMMON VARIABLE IMMUNODEFICIENCY
☐	LRBA	LIPOPOLYSACCHARIDE RESPONSIVE BEIGE-LIKE ANCHOR PROTEIN
☐	HIGM***	HYPER IGM
☐	PERGRA	PERFORIN GRANZYME
☐	MSMD	MENDELIAN SUSCEP TO MYCOBACT DISEASE **(Mon-Thurs ONLY)**
☐	PID1	PRIMARY IMMUNODEFICIENCY 1
☐	PID2	PRIMARY IMMUNODEFICIENCY 2
☐	THIL17	T HELPER IL17 **(Mon-Thurs ONLY)**
☐	TREG***	T REGULATORY-FOXP3
☐	XLP***	X-LINKED LYMPH PROLIF SYNDROME
☐	SGOF***	STAT GAIN-OF-FUNCTION

NOTE: THIL17 NOT to be collected on patients < 1 year of age

SPECIMEN DELIVERY ADDRESS	CLINICAL IMMUNODIAGNOSTIC LAB USE ONLY
Send samples at ROOM TEMPERATURE by FED EX First Overnight 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.*** *****NOTE: Specimens for these tests sent for arrival on Friday must be received by 9am or the test will be cancelled**	Date Received: _______________ Time: __________ ☐AM ☐PM Specimen Type: ☐ *PB* ☐ *Other:* _________ # of vials: ___________ Anit-coagulant: ☐ *Sodium Heparin* ☐ *Other:* __________ Pre-Analytic Condition: ☐ Satisfactory ☐ Unsatisfactory *Def Code:* _____ Notes: ____