Clinical Flow Cytometry Laboratory
Department of Laboratory Medicine
Boston Children's Hospital
300 Longwood Ave., Hale B2-443, Boston, MA, 02115
Phone: 617-355-7620 | Fax: 617-730-0383
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Boston Children's Hospital
Where the world comes for answers

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Test Requisition Form

PATIENT INFORMATION

First Name _____ Last Name_____ Date of Birth: _____/_____/_____

Medical Record Number (MRN)*: _____ Date of Collection: _____/_____/_____ Time of Collection: _____

Gender: ☐ Male ☐ Female Relevant Medication: _____ Diagnosis or Reason for testing: _____

*If you do NOT have an MRN, please submit a client registration form below prior to submitting the first test order.

ORDERING PHYSICIAN

Name (print)_____ Phone: (_____)_____ Fax: (_____)_____

Email:_____ Physician Signature (Required): _____Date:_____/_____/_____

Specimen Type:
☐ **Peripheral Blood (PB)**
☐ **Bone Marrow (BM)**
☐ **Tissue (source)**_____

Shipping Instruction:
Ship specimen at **room temperature** protected from heat or cold.

Samples <u>must</u> be received within 24 hours of being drawn.

Include a completed copy of the test requisition form with each sample.

The laboratory operates 7 days a week 7 AM to 5 PM (EST).

Ship Specimen to:
Boston Children's Hospital
Lab Processing
300 Longwood Avenue
Hale B2 -440
Boston, MA 02115
Tel: 617-355-6353
Fax: 617-730-0385

Requested Tests:

Immune System Status

Test	Specimen
☐ Acute Lymphoproliferative Syndrome (ALPS and γδ T cells)	1 ml EDTA
☐ B cell Number (Total B Lymphocyte Count)	1 ml EDTA
☐ CD40 Ligand (CD154)	1 ml Na Hep Tube
☐ Common Variable Immunodeficiency (CVID)	1 ml EDTA
☐ IL-2 Receptor gamma Chain (CD132)	1 ml EDTA
☐ Leukocyte Adhesion Deficiency 1 &2 (LAD)	1 ml EDTA
☐ Memory B cells (IgD vs CD27)	1 ml EDTA
☐ Memory T cells (CD45RA vs CCR7)	1 ml EDTA
☐ Neutrophil Oxidative Burst (DHR)	1 ml EDTA
☐ Recent Thymic Emigrants (RTE: CD45RA vs CD31)	1 ml EDTA
☐ Regulatory T cells (Tregs: CD25 vs CD127)	1 ml EDTA
☐ SCID panel (T/B subsets & Memory T cells)	1 ml EDTA
☐ T/B Subsets (TBNK: Absolute Lymphocyte Counts)	1 ml EDTA
☐ Circulating Follicular Helper T Cells (cT FH)	1 ml EDTA

Immunophenotyping

Test	Specimen
☐ Acute Myeloid Leukemia (AML) Panel	1 ml EDTA
☐ AML Minimal Residual Disease	1 ml EDTA
☐ B cell Acute Lymphoblastic Leukemia (ALL) Panel	1 ml EDTA
☐ ALL Minimal Residual Disease	1 ml EDTA
☐ Leukemia Cell Ploidy	1 ml EDTA
☐ Lymphoma Panel (4 or 7 color)	1 ml EDTA
☐ Myelodysplastic Syndrome (MDS) panel	1 ml EDTA
☐ T cell Acute Lymphoblastic Leukemia Panel	1 ml EDTA

Comments:_____

PRIMARY CONTACT FOR BILLING (submitting invoices, obtaining POs, billing questions)

First Name _____ Last Name_____ Department: _____

Institution Name _____

Mailing Address _____

City _____ State _____ Zip Code _____ Time Zone _____

Phone: (_____)_____ Fax: (_____)_____