

Children's Memorial Hospital

Diagnostic Immunology Laboratory

Contract Testing

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Chicago, Illinois 60614

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Web: www.childrensmemorial.org/depts/immunology/diagnosticlab/default.asp

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Patient Name: _____ **Date of Birth:** ___ / ___ / ___

Sex: Male _____ Female _____ **Date of Specimen Draw:** ___ / ___ / ___

Referring Institution: Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Laboratory Contact Information: Primary Contact Person: _____

Phone: _____ **Fax:** _____ **Email:** _____

Address if different from above: _____

Billing Information: Contact Person (if different from above): _____

Address (if different from above): _____

Phone: _____ **Fax:** _____

Referring Physician: Name _____ **Fax:** _____

Test Requested:

Leukemia/Lymphoma Immunophenotyping: _____

Chronic Granulomatous Disease by Flow Cytometry: _____

Leukocyte Adhesion Deficiency Type 1: _____

CD40 Ligand (CD154) Expression Assay (X-linked Hyper IgM Screen): _____

Serum Neopterin: _____

Allergy Testing (Require Special Requisition): _____

Mitogen Proliferation Assay (TdR): _____

Antigen Proliferation Assay (TdR): _____

IgG Subclass in serum: _____

Ciq Immune Complex Measurement: _____

Raji Cell Immune Complex Measurement: _____

Routine Immunophenotyping:(flow cytometry) _____

Other: _____

Note: This is a full service CAP (CLIA) accredited Immunology Laboratory, for more information on specimen requirement, other available services, etc please go to our website or phone 773.880.4361.