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Standard Immunophenotyping (SIP) Test Requisition Form

Place Barcode Label Here

Whole Blood Specimen Information
Collection Date: ____ / ____ / _____
Collection Time: ____ : ____ ☐ AM ☐ PM

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:
Email:	Phone:	Gender: ☐ M ☐ F
Address:	City: State:	Zip:

DIAGNOSIS CODES

☐ D84.9: Immunodeficiency, unspecified ☐ D89.9: Disorder involving immune mechanism, unspecified ☐ Other:

Diagnosis Comments:

PATIENT CONSENT/AUTHORIZATION FOR FLOW CYTOMETRIC IMMUNE SYSTEM EVALUATION

I authorize Virant Diagnostics to analyze my/my child's blood samples for the tests requested by my healthcare provider. The tests and their limitations have been explained to me. Test results will only be released to the healthcare providers as specified on the test requisition form.

I authorize Virant Diagnostics to submit claims to my healthcare insurers for the lab services provided. I also authorize Virant Diagnostics and my healthcare provider to release any medical information necessary to the insurers to process this claim. Payment will be made directly to Virant Diagnostics from my insurers. If my insurers pay me directly, I agree to forward the payment to Virant Diagnostics. I understand that I am responsible for any amounts not covered or paid by my insurers. Should there be no insurance coverage, Virant Diagnostics reserves the right to bill me directly.

Patient Signature: _____ **Date:** ____ / ____ / _____

Printed Name: _____ **Relationship:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Durable Power of Attorney for Health Care

INSURANCE AND PAYMENT INFORMATION

☐ Bill Insurance (Attach copy of insurance card, front and back) ☐ Bill Client ☐ Bill Patient (Cash/Check/Credit Card) ☐ Other:

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:

HEALTHCARE PROVIDER INFORMATION

Provider Name:	NPI:	
Organization:	Phone:	
Address:	City: State:	Zip:

Provider Authorization Signature: _____ **Date:** ____ / ____ / _____

SPECIMEN AND ORDER REQUIREMENTS

Specimen Collection
- *2 EDTA tubes, purple-top tube with minimum 3 mL of whole blood (A complete blood count, or CBC, with differential is required and will be performed)*

Specimen Shipment
- *Ship specimens with an ice pack.*

TEST INFORMATION

☐ **Lympho-phenotyping Tests:** Includes the tests listed below
1. **Lymphocyte Monitoring** for T cell subsets, B and NK cells, γ/δ and α/β T cells, NKT cells, and activation
2. **B Cell Maturation Evaluation** for B cell development in peripheral blood
3. **Memory CD8 and CD4 Cells Test** (CD45RO and CD45RA)
4. **Dendritic Cell Panel**

FOR LABORATORY USE ONLY

Accession #:	Patient ID:
Client/Physician ID:	Date Received: ____ / ____ / _____ Time Received: ____ : ____ ☐ AM ☐ PM

Please visit our webpage at www.virantdx.com/testing-solutions/flow-cytometry/
and contact us at info@virantdx.com or (877) 888-2973 for any inquiries.