NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

700 Children's Drive, Columbus, Ohio 43205
P: (614) 722-5477 / (800) 934-6575
F: (614) 722-5478 / (877) 722-5478
NationwideChildrens.org/Lab

Practice/ Office Name: _____
Address: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Ship samples to the CPA Lab, Room C1955

Recipient Patient Bill

Patient Information	
Legal Last Name:	
First Name:	MI:
MRN/ Patient ID:	
DOB:	
Address:	
City, State, Zip:	
Phone #: ( )	
Race:	
Ethnicity:	
Sex: ☐ Male ☐ Female	
Specimen Information	
Collection Date:	Time: ☐ AM ☐ PM
Collected By (full name):	
Storage Temp: ☐ Refrigerated ☐ Frozen ☐ Room Temperature	

Parent/Guardian / Billing Information	
Guardian Legal Last Name:	
Guardian First Name:	MI:
Patient Relationship:	
Guardian Contact Phone #: ( )	
Subscriber Legal Last Name:	
Subscriber First Name and MI:	
Subscriber DOB:	Sex: ☐ Male ☐ Female
Subscriber Social Security #:	
Subscriber Phone #: ( )	
Subscriber Address (if different from patient):	
Insurance Co. Name:	
Policy #:	Group #:
Insurance Address:	
Secondary Insurance Co. Name:	

BMT ENGRAFTMENT / CHIMERISM TEST REQUISITION

****This sample is from: ☐ Recipient ☐ Donor**

MOLECULAR (DNA-BASED) TESTING

☐ **PRE-TRANSPLANT ANALYSIS, BMT ENGRAFTMENT [BMPR]**
Submit sample(s) from both the recipient and the donor.

☐ **RECIPIENT**
- ☐ Peripheral blood, EDTA purple top tube
- ☐ Bone marrow, EDTA purple top tube

☐ **DONOR 1**
- ☐ Peripheral blood, EDTA purple top tube
- ☐ Other sample type: _____

☐ **DONOR 2**
- ☐ Peripheral blood, EDTA purple top tube
- ☐ Other sample type: _____

☐ **POST-TRANSPLANT ANALYSIS, BMT ENGRAFTMENT [BMPT]**
Select sample types to be tested.
- ☐ Peripheral blood, EDTA purple top tube
- ☐ Bone marrow, EDTA purple top tube
- ☐ Sorted Cells (CD3/CD33) [XSORT - 1 tube (NaHep or EDTA)] ☐ Peripheral Blood ☐ Bone Marrow
- ☐ Sorted Cells (CD3/CD33/CD19/CD56) [XSORT - 2 tubes (NaHep or EDTA)] ☐ Peripheral Blood ☐ Bone Marrow

FISH TESTING - DONOR MUST BE SEX MISMATCHED

☐ **POST-TRANSPLANT CHIMERISM FISH (XX/XY) [CHIMFISH]**
Only peripheral blood accepted.
- ☐ Peripheral blood, EDTA purple top tube
- ☐ Sorted Cells (CD3/CD33) [XSORT - 1 tube (NaHep or EDTA)]
- ☐ Sorted Cells (CD3/CD33/CD19/CD56 [XSORT - 2 tubes (NaHep or EDTA)]

RECIPIENT AND DONOR (CURRENT & PREVIOUS) INFORMATION IS REQUIRED

RECIPIENT
Name: _____
DOB or MR#: _____

DONOR 1
Name or ID #1: _____
ID #2: _____
Sex: ☐ Male ☐ Female

DONOR 2
Name or ID #1: _____
ID #2: _____
Sex: ☐ Male ☐ Female

ADDITIONAL DONOR INFORMATION (MARK IF APPLICABLE):
☐ Stem Cell Donor OR ☐ Cytotoxic T Lymphocyte (CTL) Donor

DATE OF TRANSPLANT: _____
DATE OF LAST STEM CELL INFUSION: _____
DATE OF LAST CTL INFUSION: _____
DIAGNOSIS: _____
OTHER RELEVANT CLINICAL INFORMATION: _____

Diagnosis/ ICD-10 _____ Physician (Print name) _____ Physician's Signature (Required) _____

Date: _____ Time: _____