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

Ship To: Nationwide Children's Hospital
Laboratory Services Room C1955
Attention: Diagnostic Immunology Lab
700 Children's Drive,
Columbus, OH 43205
P: (800) 934-6575 F: (877) 722-5478

ADENOSINE DEAMINASE 2 ENZYME ACTIVITY ASSAY (ADA2)
PATIENT INFORMATION FORM

Name: _____
MRN#: _____
Sex ☐ Male ☐ Female ☐ Other: _____ DOB: _ / _ / _____ MM/DD/YYYY
Physician: _____
Institution/ Hospital: _____
Specimen Information:
Collection Date: _____ / _____ / _____ mm/dd/yyyy Collection Time: _____ [☐] A.M. [☐] P.M.

IF AVAILABLE, PLACE PATIENT LABEL HERE

1. Clinical Diagnosis:

_____
_____
_____

2. Clinical Features:

_____
_____
_____

3. Was genetic testing performed? ☐ Yes ☐ No
If yes, were relevant variants (pathogenic, VUS) identified: variant information (cDNA, protein, transcript)? Is variant heterozygous, compound heterozygous or homozygous?

_____
_____

If question 3 was answered as "Yes", please answer the following questions: Are family members affected? ☐ Yes ☐ No
Did parents and/or siblings undergo genetic testing? ☐ Yes ☐ No
Are parents carriers? ☐ Yes ☐ No

4. Is the patient receiving anti-TNF therapy? ☐ Yes ☐ No
If yes, specify dose and duration :

_____

5. Has the patient undergone a hematopoietic cell transplant (HCT): ☐ Yes ☐ No
If yes, specify when it was performed and transplant details:

_____

6. Is this a pre-treatment evaluation (diagnostic): ☐ Yes ☐ No

7. Is this a post-treatment evaluation (monitoring): ☐ Yes ☐ No

Note: In addition to this form, please complete and send the **Diagnostic Immunology Testing requisition form by adding all the details for the patient, sample, institution, billing details and marking the appropriate tests to be ordered on the sample.