

MONOCYTE TYPE I AND II INTERFERON (IFN) SIGNATURE QUANTITATION BY FLOW CYTOMETRY (T1A2MP) PATIENT INFORMATION FORM

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|---|---|
| Name: _____ MRN#: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____ DOB: _ / _ / _____ MM/DD/YYYY Physician: _____ Institution/ Hospital: _____ Specimen Information: Collection Date: ____ / ____ / ____ mm/dd/yyyy Collection Time: _____ [<input type="checkbox"/>] A.M. [<input type="checkbox"/>] P.M. | IF AVAILABLE, PLACE PATIENT LABEL HERE |
|---|---|

1. Clinical Diagnosis:

2. Clinical Features:

3. Is the patient on steroids? ☐ Yes ☐ No

If yes, specify the dose and duration: _____

4. Is the patient receiving Emapalumab? ☐ Yes ☐ No

5. Is the patient receiving JAK inhibitor (JAKi) therapy? ☐ Yes ☐ No

If yes, specify drug, dose and duration (e.g. ruxolitinib, baricitinib, tofacitinib etc.): _____

6. Is the patient on anifrolumab (or other type I IFN-blocking therapy, e.g. sifalimumab): ☐ Yes ☐ No

If yes, specify the dose and duration: _____

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

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

9. Recent viral infection, including COVID-19 (within past 2-4 weeks): ☐ Yes ☐ No