

Instructions: Provide the requested clinical information below for appropriate interpretation of test result.

Specimens must be shipped overnight at **Ambient** temperature (20° C– 25° C). Specimens that arrive at temperatures above the ambient temperature undergo varying degrees of hemolysis, which may interfere with the performance of the assay. **Samples should not be refrigerated or frozen**.

Patient Information

Patient Name (Last, First, Mi	iddle)			Birth Date (mm-d	d-уууу)	Sex □ M	ale 🗆] Female
Patient ID (Medical Record Number, if available)								
Referring Provider Name	Phone		Fax*					
Other Contact Name (Last,	Phone		Fax*					
*Fax number given must be from a fax machine that complies with applicable HIPAA regulations. Reason for Testing								
Baseline analysis:	□ Yes	🗆 No						
Longitudinal monitoring: Other:	□ Yes	🗆 No	If Yes and available, provide date of last sample sent (mm-dd-yyyy):					
Treatment History Check all that apply.								
Hematopoietic Cell Transplant (HCT) Specify allogeneic, autologous, cord blood, haploidentical								
Pre-HCT:	□ Yes	🗆 No	Conditioning date (mm-dd-yyyy):					
Post-HCT:	\Box Yes	🗆 No	HCT date (mm-dd-yyyy): Conditi			received:	□ Yes	🗆 No
T-cell depleted HCT:	🗆 Yes	🗆 No						
Transplant type:	🗆 Allo	🗆 Auto	🗆 Cord 🛛 Haplo					
Thymus transplant:								
Post-Thymus transplant:	🗆 Yes	🗆 No	Thymus transplant date (mm-dd-y	ууу):				
Clinical History								
Diagnosis Check all that Hematopoietic ce Severe combined DiGeorge Syndro If on immunosup	 CD3 T-cell lymphopenia CD4 T-cell lymphopenia CD8 T-cell lymphopenia below 							
Autoimmune disease, spe	ecify:							
Viral infection, specify:								
Malignancy, specify:								
Other Relevant Information								