

Ocular Immunology Laboratory, Oregon Health & Science University
Biomedical Research Building, Room 253, 3181 SW Sam Jackson Park Road
Portland, OR 97239, USA; 503-418-2543 (Phone)/ 503-418-2541 (FAX)

TEST REQUISITION

PATIENT INFORMATION

Ocular Immunology Accession Number (leave blank): OI-	
OHSU MRN (leave blank):	Serum/Plasma (ml)
Patient Last Name:	First Name:
Date of Birth:	Sex:
Date Collected:	Date Received:

REFERRING LABORATORY/PHYSICIAN Name:			
Street:			
City:	State:	Zip:	Country:
Phone:	Fax:		
Referring Physician Name:			
ICD-10 Diagnosis Code:		Date of Onset:	

REQUIRED PRE-PAYMENT - Insurance will not be billed		
<input type="checkbox"/> Check #	<input type="checkbox"/> Money Order#	<input type="checkbox"/> Wire transfer
Credit Card: <input type="checkbox"/> Visa or <input type="checkbox"/> Master Card		
Cardholder Name		
Card Number:	Expires	/
Cardholder Signature		

TEST REQUESTED (check the box on the left)

	ARP	Autoimmune Retinopathy Panel by Immunoblot	\$640
	CARP	CAR Panel by Immunoblot and Immunohistochemistry	\$680
	MARP	MAR Panel by Immunoblot and Immunohistochemistry	\$520
	BEST	Anti-bestrophin Autoantibodies	\$80
	AMDP	AMD Panel by Immunoblot	\$400
	ARW	Western blot for anti-retinal autoantibodies - only in follow up cases	\$550
	ONS	Western blot for anti-optic nerve autoantibodies in the serum	\$350
	ONCSF	Western blot for anti-optic nerve autoantibodies in CSF	\$350

CLINICAL HISTORY AND FINDINGS (Provide the appropriate information: include chart note or an accompanying letter)