Ocular Immunology Laboratory, Oregon Health & Science University
Lamfrom 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		
□ Check #	□ Money Order#	□ Wire transfer
Credit Card: [] Visa or [] Master Card		Billing zip code:
Cardholder Name		
Card Number:		Expires /
Cardholder Signature		

TEST REQUESTED (check the box on the left)

	ARP	Autoimmune Retinopathy Panel by Immunoblot	$700
	CARP	CAR Panel by Immunoblot and Immunohistochemistry	$850
	MARP	MAR Panel by Immunoblot and Immunohistochemistry	$650
	BEST	Anti-bestrophin Autoantibodies	$90
	AMDP	AMD Panel by Immunoblot	$440
	ARW	Western blot for anti-retinal autoantibodies - only in follow up cases	$650
	ONS	Western blot for anti-optic nerve autoantibodies in the serum	$385
	ONCSF	Western blot for anti-optic nerve autoantibodies in CSF	$385

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