Complete, print and submit.

Reset Form

MAYO CLINIC LABORATORIES

TCR V beta Spectratyping Assay Patient Information

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, Middle)*	Birth Date *(mm-dd-yyyy)*	Gender ☐ Male ☐ Female
Patient ID (Medical Record Number, if available)		
Referring Physician Name *(Last, First)*	Phone	Fax*
Other Contact *(Last, First)*	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: ☐ Yes ☐ No If Yes and available, provide date of last sample sent *(mm-dd-yyyy)*: _____

Other: _____

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: ☐ Yes ☐ No	HCT date *(mm-dd-yyyy)*:	Conditioning 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-yyyy)*:		

Clinical History

Diagnosis (Check all that apply.)

- ☐ Hematopoietic cell transplantation
- ☐ Severe combined immunodeficiency
- ☐ DiGeorge Syndrome (DGS)
- ☐ If on immunosuppression (GVHD or other therapeutic purposes), specify below
- ☐ CD3 T-cell lymphopenia
- ☐ CD4 T-cell lymphopenia
- ☐ CD8 T-cell lymphopenia

Autoimmune disease (specify):

Viral infection (specify):

Malignancy (specify):

Other Relevant Information

Print