



Instructions: Send specimen Monday through Thursday only. Specimen should arrive within 48 hours of draw. Draw and package specimen under strict ambient conditions as close to shipping time as possible. Ship specimen overnight in an ambient mailer (Ambient Mailer-Critical Specimens Only-T668).

Patient Information

Patient Name <i>(Last, First, Middle)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring Physician Name <i>(Last, First)</i>	Phone	Fax*
Other Contact Name <i>(Last, First)</i>	Phone	Fax*

*Fax number given must be from a fax machine that complies with applicable HIPAA regulations.

Reason for Testing

Treatment History (check all that apply)

Hematopoietic Cell Transplant (HCT) or Bone Marrow Transplant (BMT)		Conditioning Date <i>(mm-dd-yyyy)</i>	
Pre-Stem Cell or Bone Marrow Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No			
Post-Stem Cell or Bone Marrow Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No		HCT/BMT Date <i>(mm-dd-yyyy)</i>	
Number of Days Post HCT/BMT	T-Cell Depleted HCT <input type="checkbox"/> Yes <input type="checkbox"/> No	Conditioning Received <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thymus Transplant	Post-Thymus Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	Thymus Transplant Date <i>(mm-dd-yyyy)</i>	
Pre-Thymus Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No			
HAART	Initiation of HAART Date <i>(mm-dd-yyyy)</i>	Pre-HAART specimen <input type="checkbox"/> Yes <input type="checkbox"/> No	Post-HAART specimen <input type="checkbox"/> Yes <input type="checkbox"/> No
Receiving HAART <input type="checkbox"/> Yes <input type="checkbox"/> No			

Clinical History

Diagnosis (check all that apply)

<input type="checkbox"/> Hematopoietic cell or bone marrow transplant	<input type="checkbox"/> Severe combined immunodeficiency	<input type="checkbox"/> CD3 T-cell lymphopenia
<input type="checkbox"/> Allograft	<input type="checkbox"/> DiGeorge Syndrome	<input type="checkbox"/> CD4 T-cell lymphopenia
<input type="checkbox"/> Autograft	<input type="checkbox"/> HIV positive	<input type="checkbox"/> CD8 T-cell lymphopenia
<input type="checkbox"/> Cord blood		
<input type="checkbox"/> Other (describe below)		

Other Relevant Information