

REPRODUCTIVE IMMUNOLOGY ASSOCIATES
 6850 SEPULVEDA BLVD., SUITE 210, VAN NUYS, CALIFORNIA 91405
 PHONE (818) 781-5195 FAX (818) 781-5197
 TAX ID NUMBER 95-4314355

LAB REQUISITION FORM

PATIENT NAME _____ REFERRING MD. _____
 PATIENT ADDRESS _____ MD PHONE NO. _____
 _____ MD FAX NO. _____
 PATIENT PHONE _____ COLLECTION DATE _____
 BIRTH DATE _____ SSN _____ COLLECTION TIME _____

- | DIAGNOSIS | |
|--------------------------|---------------------------------------|
| <input type="checkbox"/> | 286.5 APA Syndrome |
| <input type="checkbox"/> | 279.4 Autoimmune Dis. Unclassified |
| <input type="checkbox"/> | 629.9 SAB w/o current pregnancy |
| <input type="checkbox"/> | 646.30 SAB with current pregnancy |
| <input type="checkbox"/> | V23.2 High risk pregnancy |
| <input type="checkbox"/> | 628.9 Infertility, female nonspecific |
| <input type="checkbox"/> | 795.79 Eleveaed antibody titer |
| <input type="checkbox"/> | _____ |

- TISSUE TYPING**
- | | | | |
|--------------------------|----------------------------|-------|----------------|
| <input type="checkbox"/> | 86813 HLA A, B, C Antigens | _____ | 2 YELLOW/M & F |
| <input type="checkbox"/> | 86817 HLA DR, DQ Antigens | _____ | 2 YELLOW/M & F |
| <input type="checkbox"/> | 83898 HLA DQA1 (Alpha) | _____ | 1 PURPLE/M & F |
| <input type="checkbox"/> | 83898 HLA DQ Beta | _____ | 1 YELLOW/M & F |

- HEREDITARY THROMBOPHILIAS**
- | | | | |
|--------------------------|-----------------------------------|-------|----------|
| <input type="checkbox"/> | Factor II (Prothrombin) Mutation | _____ | 1 YELLOW |
| | 83903, 83892, 83898, 83894, 83912 | | |
| <input type="checkbox"/> | Factor V Leiden Mutation | _____ | 1 YELLOW |
| | 83903, 83892, 83898, 83894, 83912 | | |
| <input type="checkbox"/> | MTHFR | _____ | 1 YELLOW |
| | 83903, 83892, 83898, 83894, 83912 | | |

CPT	DESCRIPTION	FEE	TUBE(S)
ANTIBODIES			
<input type="checkbox"/>	83516 Antihistone Antibody	_____	1 SST
<input type="checkbox"/>	Antinuclear Ab Panel	_____	1 SST
	86039 ANA titer		
	86225 Anti ds DNA		
	86235 Anti Sm		
	86235 Anti RNP		
	86235 Anti SS-A		
	86235 Anti SS-B		
<input type="checkbox"/>	Antiphosphol. Ab Panel	_____	1 SST
	86147 Cardioliipin (IgM, G, A)		
	86147 Phosphatidic Acid (IgM, G, A)		
	86147 Phosphoethanolamine (IgM, G, A)		
	86147 Phosphoglycerol (IgM, G, A)		
	86147 Phosphoinositol (IgM, G, A)		
	86147 Phosphoserine (IgM, G, A)		
	86147 Phosphocholine (IgM, G, A)		
<input type="checkbox"/>	Antisperm Ab Panel	_____	1 SST/FEMALE
	89325 IgG		1 SST/MALE
	89325 IgA		
<input type="checkbox"/>	Leukocyte Ab Detection	_____	1 SST/FEMALE
	86021 B Cell IgG		2 GREEN/MALE
	86021 T Cell IgG		
<input type="checkbox"/>	Thyroid Ab Panel	_____	1 SST
	86376 Microsomal Ab		
	86800 Thyroglobulin Ab		
CELLULAR IMMUNITY			
<input type="checkbox"/>	Immunophenotype	_____	1 PURPLE
	88180 CD 3/CD 16/CD 56		
	88180 CD 5/CD 19		
<input type="checkbox"/>	NK Activation	_____	2 GREEN
	88180 CD 56		
	88180 CD 69		
<input type="checkbox"/>	86849 NK with IVIg	_____	2 GREEN
	86353 Lymphocyte Mitogen		
<input type="checkbox"/>	86849 Tumor Necrosis Factor	_____	2 GREEN
	88180 CD 16		
	88180 CD 56		
	88180 TNF		

- MISCELLANEOUS LABS**
- | | | | |
|--------------------------|---------------------------|-------|--------|
| | Immunoglobulins | _____ | 1 SST |
| <input type="checkbox"/> | 82784 IgG | _____ | |
| <input type="checkbox"/> | 82784 IgM | _____ | |
| <input type="checkbox"/> | 82784 IgA | _____ | |
| <input type="checkbox"/> | 85612 Lupus Anticoagulant | _____ | 1 BLUE |
| <input type="checkbox"/> | 85730 PTT | _____ | 1 BLUE |

- PANELS****
- | | | |
|--------------------------|------------------------------|------------------------|
| <input type="checkbox"/> | MISCARRIAGE | TOTAL TUBE REQUIREMENT |
| | Leukocyte Ab Detection | 1 SST/FEMALE |
| | Antiphospholipid Ab | 1 PURPLE/FEMALE |
| | Antinuclear Ab | 1 BLUE/FEMALE |
| | Lupus Anticoagulant, PTT | 2 GREEN/FEMALE |
| | HLA DQA1 | 2 GREEN/MALE |
| | Immunophenotype | 1 PURPLE/MALE |
| | NK with IVIg | |
| | Quantitative Immunoglobulins | |
| <input type="checkbox"/> | IMPLANTATION FAILURE | TOTAL TUBE REQUIREMENT |
| | Antiphospholipid Ab | 1 SST/FEMALE |
| | Antithyroid Ab | 1 PURPLE/FEMALE |
| | Antinuclear Ab | 1 BLUE/FEMALE |
| | Lupus Anticoagulant, PTT | 2 GREEN/FEMALE |
| | HLA DQA1 | 1 PURPLE/MALE |
| | Immunophenotype | |
| | NK with IVIg | |
| | Quantitative Immunoglobulins | |

****CUSTOM PANELS AVAILABLE, PLEASE CALL****

- Shipping _____
 TOTAL _____

*PAYMENT (CHECK, CHARGE CARD) MUST ACCOMPANY SPECIMEN UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.
 RIA HAS NO CONTRACTUAL AGREEMENT WITH ANY INSURANCE COMPANY.
 *ATTACH COPY OF INS CARD (FRONT AND BACK) IF PATIENT WANTS HCFA MAILED TO INS CO. INDICATE PRIMARY

BANK _____ CHECK# _____

VISA/MASTERCARD/AMER. EXP/DISCOV/DINERS _____ EXP DATE _____

AUTHORIZATION SIGNATURE (REQUIRED) _____