

**REPRODUCTIVE IMMUNOLOGY ASSOCIATES**  
 29252 CANWOOD STREET, SUITE 205, AGOURA HILLS, CA 91301  
 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**
- 286.5 APA Syndrome
  - 279.4 Autoimmune Dis. Unclassified
  - 629.9 SAB w/o current pregnancy
  - 646.30 SAB with current pregnancy
  - V23.2 High risk pregnancy
  - 628.9 Infertility, female nonspecific
  - 795.79 Eleveaed antibody titer
  - \_\_\_\_\_

- TISSUE TYPING**
- 86813 HLA A, B, C Antigens \_\_\_\_\_ 2 YELLOW/M & F
  - 86817 HLA DR, DQ Antigens \_\_\_\_\_ 2 YELLOW/M & F
  - 83898 HLA DQA1 (Alpha) \_\_\_\_\_ 1 PURPLE/M & F
  - 83898 HLA DQ Beta \_\_\_\_\_ 1 YELLOW/M & F

- HEREDITARY THROMBOPHILIAS**
- Factor II (Prothrombin) Mutation \_\_\_\_\_ 1 YELLOW  
 83903, 83892, 83898, 83894, 83912
  - Factor V Leiden Mutation \_\_\_\_\_ 1 YELLOW  
 83903, 83892, 83898, 83894, 83912
  - MTHFR \_\_\_\_\_ 1 YELLOW  
 83903, 83892, 83898, 83894, 83912

CPT	DESCRIPTION	FEE	TUBE(S)
<b>ANTIBODIES</b>			
<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	Cardiolipin (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		
<b>CELLULAR IMMUNITY</b>			
<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
  - 82784 IgG \_\_\_\_\_
  - 82784 IgM \_\_\_\_\_
  - 82784 IgA \_\_\_\_\_
  - 85612 Lupus Anticoagulant \_\_\_\_\_ 1 BLUE
  - 85730 PTT \_\_\_\_\_ 1 BLUE

- PANELS\*\***
- 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
  - 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) \_\_\_\_\_