



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 <i>(Last, First, Middle)</i>		Birth Date <i>(mm-dd-yyyy)</i>
Patient ID (Medical Record Number, if available)		
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose	Legal/Administrative Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary	

Referring Provider Information

Referring Provider 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

Baseline analysis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Longitudinal monitoring: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" and available, provide date of last sample sent <i>(mm-dd-yyyy)</i> : _____
Other: _____

Treatment History Check all that apply.

Hematopoietic Cell Transplant (HCT): <input type="checkbox"/> Allogeneic <input type="checkbox"/> Autologous <input type="checkbox"/> Cord blood <input type="checkbox"/> Haploidentical			
Pre-HCT: <input type="checkbox"/> Yes <input type="checkbox"/> No	Conditioning date <i>(mm-dd-yyyy)</i> :		
Post-HCT: <input type="checkbox"/> Yes <input type="checkbox"/> No	HCT date <i>(mm-dd-yyyy)</i> :	Conditioning received: <input type="checkbox"/> Yes <input type="checkbox"/> No	
T-cell depleted HCT: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Transplant type: <input type="checkbox"/> Allo <input type="checkbox"/> Auto <input type="checkbox"/> Cord <input type="checkbox"/> Haplo			
Thymus transplant:			
Post-Thymus transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Thymus transplant date <i>(mm-dd-yyyy)</i> :		

Clinical History

Diagnosis Check all that apply. <input type="checkbox"/> Hematopoietic cell transplantation <input type="checkbox"/> Severe combined immunodeficiency <input type="checkbox"/> DiGeorge Syndrome <input type="checkbox"/> If on immunosuppression for chronic graft-versus-host disease or other therapeutic purposes, specify below <input type="checkbox"/> CD3 T-cell lymphopenia <input type="checkbox"/> CD4 T-cell lymphopenia <input type="checkbox"/> CD8 T-cell lymphopenia
Autoimmune disease, specify:
Viral infection, specify:
Malignancy, specify:
Other Relevant Information _____ _____ _____