THE UNIVERSITY OF CHICAGO MEDICINE

UChicago MedLabs
Transplant Immunology Laboratory
5841 South Maryland Avenue
Room TW-020, MC-0006, Chicago, IL 60637
Phone 773-702-0700 Fax 773-702-7986

UChicago MedLabs

1. PATIENT INFORMATION – Required

Name _____

DOB _____ Sex F

Street _____

City _____ State _____ Zip _____

Phone _____ ◯ **RECIPIENT** ◯ **DONOR**

2. CLIENT INFORMATION - Required

Institution/Group Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

_____ _____

Ordering Physician NPI

3. BILLING CLASSIFICATION: Check only one box. If no box is checked, UChicago MedLabs will bill Client.

◯ **BILL CLIENT**

Client Account Code: _____

Contact Name: _____

Phone: _____

Physician Signature: _____

Date: _____

◯ **BILL PATIENT INSURANCE** Complete Section 4

Please check for HMO authorization.

☐ Check here if prior authorization/ referral form is attached. Failure to include may result in coverage denial.

☐ Check here if patient is self-pay and is aware that they will billed for our services. Bills will be sent to the address listed in box 1.

Patient Signature: _____

4. PATIENT INSURANCE INFORMATION * * Please attach a copy of the front/back of patient's insurance card(s) * *

_____ _____ _____

Subscriber (if different from patient) DOB Relationship SS#

Primary Insurance Co. _____

_____ _____

Policy Number Group Number

_____

Insurance Company Address

Secondary Insurance Co. _____

_____ _____

Policy Number Group Number

_____

Insurance Company Address

5. SPECIMEN INFORMATION – Required **(Fill-out one requisition per individual to be tested)**

COLLECTION DATE: _____

◯ RECIPIENT: HEMATOPOIETIC STEM CELL TRANSPLANT (HCT) WORKUP: CPT 81378, 81382

DIAGNOSIS: _____

RACE (for recipient only): ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Native-American ☐ Other

◯ DONOR: HCT LOW RESOLUTION WORKUP (W/OUT REFLEX TESTING): CPT 81373, 81376

RECIPIENT NAME: _____ RELATION TO RECIPIENT: _____

6. TESTING REQUESTED:

☒ Initial HLA Testing: 2 ACD-Solution A (Yellow top tubes)
2 No Anticoagulant (Red top tubes)

☐ PRELIMINARY SEARCH Check if you would like to have a preliminary donor search run at no cost for the recipient.
Please provide Disease Status for a detailed preliminary donor search: ☐ Induction ☐ In Treatment ☐ Remission ☐ Relapse

UNIVERSITY OF CHICAGO HCT CONTACTS:

For questions you may contact the **Search Coordinator** or for physician to physician communication please contact either **Transplant Specialist.**

MUD/Allogeneic Search Coordinator
Lillian (Kate) Villatuya
lvillatuya@medicine.bsd.uchicago.edu
Office: 773-702-1613

Transplant Specialist
Andrew Artz, MD
aartz@medicine.bsd.uchicago.edu
Office: 773-702-4400

Transplant Specialist
Michael R. Bishop, MD
mbishop@medicine.bsd.uchicago.edu
Office: 773-702-9297

Please fax completed form to 773-702-7986

A collection kit will be sent to your practice location once coverage is verified.

Print Form