



# OHSU MOLECULAR DIAGNOSTIC CENTER

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## ENGRAFTMENT TESTING REQUISITION

Sample Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_ \*ICD9 code: \_\_\_\_\_

### Recipient Information

MR#: \_\_\_\_\_ Acct. #: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Female  Male

Birth Date: \_\_\_/\_\_\_/\_\_\_

Has this patient received more than one Bone Marrow Transplant?

Yes  No

### Donor Information

MR# or Donor's ID #: \_\_\_\_\_

Female  Male

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_

Is the donor a relative of the recipient?

No  Yes, specify \_\_\_\_\_

### Referral Information

Referring MD: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Transplant Information

Date of Transplant: \_\_\_\_\_

Specimen collected \_\_\_\_\_ days after transplant

### Test Information

#### Test ordered:

- Recipient Pre-Transplant Sample Storage (ENG)
- Post-transplant Chimerism DNA Testing (PTE)
- Donor Sample Storage (DEG)

#### Specimen Type

- Blood
- Bone Marrow
- Other \_\_\_\_\_