TEST REQUISITION

Ocular Immunology Laboratory
Oregon Health & Science University
Biomedical Research Building, Room 253
3181 SW Sam Jackson Park Road
Portland, OR 97239, USA
503-418-2543 (Phone), 503-418-2541 (FAX)

WE DO NOT BILL INSURANCE, NOR TAKE PT CALLS

PATIENT INFORMATION

Patient Last Name_____ _____First Name_____

Date of Birth (Month/day/year)_____Gender _____

Date Collected_____ Received Date_____

Ocular Immunology Accession #_____

REFERRING LABORATORY /PHYSICIAN Name_____

Street: _____

City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

Referring Physician Name: _____

IDC-9 Diagnosis Code _____Date of Onset _____

CLINICAL HISTORY AND FINDINGS (Complete the appropriate information below or include in an accompanying letter)

INSURANCE will not be billed

REQUIRED PRE-PAYMENT - Method:	
□ Check #	□ Money Order
Credit Card: [] Visa or [] Master Card	
Cardholder Name	
Cardholder Signature	
Card Number	Expires _____/_____

TEST REQUESTED

[ ] Western blot for anti-retinal antibodies (CAR, MAR, Autoimmune Retinopathy); $495

[ ] Western blot for anti-retinal antibodies in ocular fluids; $495

[ ] Immunohistochemistry for anti-retinal antibodies (CAR, MAR, Autoimmune Retinopathy); $300

[ ] Western blot for anti-optic nerve antibodies (Optic Neuropathy); $330

[ ] Western blot for anti-optic nerve antibodies in CSF; $330

Rev 7/2014