

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

**TEST REQUISITION**

**PATIENT INFORMATION**

<b>Ocular Immunology Accession Number</b> (leave blank): <b>OI-</b>	
OHSU MRN (leave blank):	Serum/Plasma (ml)
Patient Last Name:	First Name:
Date of Birth:	Sex:
Date Collected:	Date Received:

<b>REFERRING LABORATORY/PHYSICIAN</b> Name:			
Street:			
City:	State:	Zip:	Country:
Phone:	Fax:		
Referring Physician Name:			
ICD-10 Diagnosis Code:		Date of Onset:	

<b>REQUIRED PRE-PAYMENT - Insurance will not be billed</b>		
<input type="checkbox"/> Check #	<input type="checkbox"/> Money Order#	<input type="checkbox"/> Wire transfer
Credit Card: <input type="checkbox"/> Visa or <input type="checkbox"/> Master Card	Billing zip code:	
Cardholder Name		
Card Number:	Expires /	
Cardholder Signature		

**TEST REQUESTED** (check the box on the left)

	<b>ARP</b>	Autoimmune Retinopathy Panel by Immunoblot	\$700
	<b>CARP</b>	CAR Panel by Immunoblot and Immunohistochemistry	\$850
	<b>MARP</b>	MAR Panel by Immunoblot and Immunohistochemistry	\$650
	<b>BEST</b>	Anti-bestrophin Autoantibodies	\$90
	<b>AMDP</b>	AMD Panel by Immunoblot	\$440
	<b>ARW</b>	Western blot for anti-retinal autoantibodies - only in follow up cases	\$650
	<b>ONS</b>	Western blot for anti-optic nerve autoantibodies in the serum	\$385
	<b>ONCSF</b>	Western blot for anti-optic nerve autoantibodies in CSF	\$385

<b>CLINICAL HISTORY AND FINDINGS</b> (Provide the appropriate information: <u>include chart note</u> or an accompanying letter)