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

Ocular Immunology Accession Number (leave blank): **OI-**	
OHSU MRN (leave blank):	Serum/Plasma (ml)
Patient Last Name:	First Name:
Date of Birth (month/day/year):	Sex:
Date Collected: (month/day/year):	Date Received:

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

REQUIRED PRE-PAYMENT - Insurance will not be billed		
□ Check #	□ Money Order#	□ Wire transfer
Credit Card: [] Visa or [] Master Card	Billing zip code:	
Cardholder Name	Phone number:	
Card Number:	Expires /	
Cardholder Signature		

TEST REQUESTED (check the box on the left)

	ARP	Autoimmune Retinopathy Panel by Immunoblot	$737
	CARP	CAR Panel by Immunoblot and Immunohistochemistry	$895
	MARP	MAR Panel by Immunoblot and Immunohistochemistry	$684
	BEST	Anti-bestrophin Autoantibodies	$95
	AMDP	AMD Panel by Immunoblot	$463
	ARW	Western blot for anti-retinal autoantibodies - only in follow up cases	$684
	ONS	Western blot for anti-optic nerve autoantibodies in the serum	$405
	ONCSF	Western blot for anti-optic nerve autoantibodies in CSF	$405

CLINICAL HISTORY AND FINDINGS (Include chart notes or an accompanying letter)