U I D L
U I Diagnostic Laboratories

IMMUNOPATHOLOGY REQUISITION

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Fax: 319-384-7213

FOR CLIENT USE ONLY: Requisition Date:_________________
Completed By: ______________ Accn# ____________________________

FOR UIDL USE ONLY: UIDL Accn #______________________________
UIDL MRN#

PART A - PATIENT INFORMATION - *Required*

Patient Name:
Street:
City: St: Zip:
Phone: ( )
Date of Birth: Gender: ☐Male ☐Female

PART B - PROVIDER INFORMATION - *Required*

Referring Institution:
Street:
City:
Phone: Fax:
Referring Physician:
Referring Physician NPI:

PART C) SPECIMEN INFORMATION

Date Collected: ______/______/______ Time: ____________ Specimen Type: ☐**Serum** ☐**Urine** ☐**CSF** ☐**Other (specify):**___________________________

Required ICD-9 codes: 1. 2. 3. 4.

TEST(S) REQUESTED: Refer to the UIDL TEST DIRECTORY for specimen requirements and CPT Code information..

PANELS (CPT's)

- ☐ ANCA PANEL
  Includes: ANCA screen and consultation (86255 & 86255-26). Titer and consultation (86256 & 86256-26) with confirmatory EIA(s) such as MPO (83520) and PR3 (83520) performed if ANCA screen is positive or as needed to confirm interpretation.
- ☐ CELIAC DISEASE PANEL
  Includes: Endomysial IgA screen and consultation (86255 & 86255-26), titer and consultation if positive (86256 & 86256-26), Deamidated Gliadin Peptides IgA & IgG Antibody (83520x2), and Tissue Transglutaminase Antibody (83520)

ALPHABETICAL TESTS

- ☐ ADRENAL CORTEX ANTIBODY/CONSULTATION
- ☐ ANTINUCLEAR ANTIBODY SCREEN (ANA) WITH REFLEX TITER (Titer performed only if screen is positive)
- ☐ ANCA SCREEN WITH CONSULTATION AND REFLEX TITER (Titer performed only if screen is positive)
- ☐ ANCA "UC-ANCA" SCREEN AND CONSULTATION
- ☐ ANTI-SACCHAROMYCES CEREVISIAE ANTIBODY- IgG and IgA

ALPHABETICAL TESTS

- ☐ BETA-2 GLYCOPROTEIN ANTIBODY- IgG and IgM
  - ☐ BETA-2 GLYCOPROTEIN ANTIBODY- IgG only
  - ☐ BETA-2 GLYCOPROTEIN ANTIBODY- IgM only
- ☐ CARDIOLIPIN ANTIBODY – IgG and IgM
  - ☐ CARDIOLIPIN ANTIBODY – IgG only
  - ☐ CARDIOLIPIN ANTIBODY – IgM only
- ☐ CYCLIC CITRULLINATED PEPTIDE ANTIBODY
- ☐ DOUBLE STRANDED DNA ANITBODY (DS-DNA)
- ELECTROPHORESIS
  - ☐ SERUM PROTEIN ELECTROPHORESIS
  - ☐ URINE PROTEIN ELECTROPHORESIS
  - ☐ URINE PROTEIN ELECTROPHORESIS – 24 HOUR
- ELECTROPHORESIS - IMMUNOFIXATION
  - ☐ SERUM IMMUNOFIXATION ELECTROPHORESIS
  - ☐ URINE IMMUNOFIXATION ELECTROPHORESIS
- ☐ ENDOMYSIAL IgA SCREEN/TITER/CONSULTATION
- ☐ ENDOMYSIAL IgG SCREEN/TITER/CONSULTATION
- ☐ FETAL ERYTHROCYTE DETECTION AND QUANTITATION
- ☐ DEAMIDATED GLIADIN PEPTIDES ANTIBODY – IgG and IgA
  - ☐ DEAMIDATED GLIADIN PEPTIDES ANTIBODY – IgG only
  - ☐ DEAMIDATED GLIADIN PEPTIDES ANTIBODY – IgA only
- ☐ GLOMERULAR BASEMENT MEMBRANE ANTIBODY

ALPHABETICAL TESTS

- ☐ MITOCHONDRIAL ANTIBODY SCREEN WITH REFLEX TITER (Titer performed only if screen is positive)
- ☐ MYELOPEROXIDASE ANTIBODY
- ☐ OLIGOCLONAL BANDS/CONSULTATION (M.S. Screen – Requires both serum and CSF)
- ☐ PARIETAL CELL AB. SCREEN/CONSULTATION REFLEX TITER (Titer performed only if screen is positive)
- ☐ PEMPHIGUS/PEMPHIGOID/EBA AB. SCREEN WITH CONSULTATION (Titer performed only if screen is positive)
- ☐ PROTEINASE 3 ANTIBODY
- ☐ RNP (U1-RNP) /SM ANTIBODIES
  - ☐ RNP (U1-RNP) ONLY
  - ☐ SM ONLY
- ☐ SCL-70 (DNA TOPOISOMERASE I) ANTIBODY
- ☐ SMOOTH MUSCLE ANTIBODY SCREEN WITH TITER (Titer performed only if screen is positive)
- ☐ SS-A (Ro) & SS-B (La) ANTIBODY (orders both)
  - ☐ SS-A (Ro) ANTIBODY only
  - ☐ SS-B (La) ANTIBODY only
- ☐ STRIATED MUSCLE AB. SCREEN/CONSULTATION WITH TITER (Titer performed only if screen is positive)
- ☐ TISSUE TRANSGLUTAMINASE ANTIBODY., IgA

PART D - SEND BILL TO: (Required)

☐ **Referring Institution Contact:** ____
Address:
City, St, Zip code:
☐ **Patient's Insurance** (Complete billing information must be provided or referring institution may be billed)
(Required information is in red)

Please note that the correct birth date of all policy holders is required information. Please attach the following to the requisition:

(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.

OR

(2) a printout with patient demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for the Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens.