NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Ship To: Nationwide Children's Hospital
Laboratory Services Room C1955
Attention: Diagnostic Immunology Lab
700 Children's Drive,
Columbus, OH 43205
P: (800) 934-6575 F: (877) 722-5478

MONOCYTE TYPE I AND II INTERFERON (IFN) SIGNATURE QUANTITATION BY FLOW CYTOMETRY (T1A2MP) PATIENT INFORMATION FORM

Name: _____
MRN#: _____
Sex ☐ Male ☐ Female ☐ Other: _____ DOB: _ / _ / _____ MM/DD/YYYY
Physician: _____
Institution/ Hospital: _____
Specimen Information:
Collection Date: _____ / _____ / _____ mm/dd/yyyy Collection Time: _____ [☐] A.M. [☐] P.M.

IF AVAILABLE, PLACE PATIENT LABEL HERE

1. Clinical Diagnosis:

_____
_____
_____

2. Clinical Features:

_____
_____
_____

3. Is the patient on steroids? ☐ Yes ☐ No
If yes, specify the dose and duration: _____

4. Is the patient receiving Emapalumab? ☐ Yes ☐ No

5. Is the patient receiving JAK inhibitor (JAKi) therapy? ☐ Yes ☐ No
If yes, specify drug, dose and duration (e.g. ruxolitinib, baricitinib, tofacitinib etc.): _____
_____

6. Is the patient on anifrolumab (or other type I IFN-blocking therapy, e.g. sifalimumab): ☐ Yes ☐ No
If yes, specify the dose and duration: _____

7. Is this a pre-treatment evaluation (diagnostic): ☐ Yes ☐ No

8. Is this a post-treatment evaluation (monitoring): ☐ Yes ☐ No

9. Recent viral infection, including COVID-19 (within past 2-4 weeks): ☐ Yes ☐ No

Note: In addition to this form, please complete and send the **Diagnostic Immunology Testing requisition form by adding all the details for the patient, sample, institution, billing details and marking the appropriate tests to be ordered on the sample.