

IBT Laboratories

11274 Renner Blvd. Lenexa, KS 66219

(913) 492-2224 (800) 637-0370

CLIA#17D0448989

Updated 01/27/09

Call 800-637-0370 for specimen/shipping requirements.

CHRONIC URTICARIA TESTING

403005 CU (Chronic Urticaria)
Index™ Panel
2103 CU Index™ (Functional Anti FcεR)
2004 Thyroid Stimulating Hormone
2005 Anti-Thyroglobulin IgG
322 Anti-Thyroid Peroxidase IgG
2105 Anti-IgE

T-Cell Proliferation/Activation Tests

401760 Cylex ImmuKnow™ (PHA)
403065 T Cell Fx™ Select
403066 T Cell Fx™ Complete

Molecular Diagnostic Tests

1133 Microsporidia

Immunogenicity

1210 Tysabri Immunogenicity

CELLULAR IMMUNOLOGY**BasoFunction™ HRT****Analgesics**

501361 Acetaminophen
501369 Diclofenac
501370 Dipyron/Metamizole
501360 Ibuprofen
501371 Indomethacin
501365 Lys-Aspirin
501372 Mefenamic Acid
501373 Phenylbutazone Acid
501374 Propyphenazone

Anesthetic

501375 Atracurium
501353 Lidocaine
501376 Mivacurium
501377 Pancuronium
501367 Propofol
501378 Rocuronium
501357 Suxamethonium
501380 Vecuronium

Antibiotics

501381 Amoxicillin
501382 Ampicillin
501383 Cefamandole
501384 Cefazolin
501385 Cefuroxime
501351 Cephalosporin
501352 Ciprofloxacin
501355 Penicillin:
(Benzylpenicilloyl-
Polylysine)
501354 Penicillin: minor det mix
501356 Sulfamethoxazole
501358 Tetracycline
501386 Trimethoprim

BasoFunction™ HRT (Cont.)**Food Additives**

501390 Amaranth
501392 Brilliant Black BN
501389 Chromotrope B
501391 Erythrosine
501363 Indigo Carmine
501366 Monosodium Glutamate MSG
501395 New Coccine
501388 Patent Blue V
501359 Potassium Metabisulphite
501362 Quinoline Yellow
501379 Sodium Benzoate
501394 Sodium Nitrite
501368 Sodium Salicylate
501387 Sunset Yellow FCF
501364 Tartrazine

Specimen Requirement:

Whole Blood preserved with Sodium Heparin (8-10 mL) and maintained at 10-25° C in an insulated container.

Shipping & Transport: Preferred specimen to arrive within 48 hours of the draw. Samples are accepted **Monday through Friday.**

Special Note: Turn around time is 3-4 days. **Hemolyzed blood will be rejected.**

Mannan-Binding Lectin

33 MBL Protein Test
34 MBL Pathway Function Test
402857 ProGenotyper™ MBL
402856 ProGenotyper™ MASP-2

Neutrophil Function

403002 Neutrophil Oxidative Burst
403054 Neutrophil Function Panel
403053 Phagocytosis Test

Cytokine	Plasma	Serum	Other
Interleukin-1β (IL-1β)	1225	1215	1411
Interleukin-2 (IL-2)	1226	1216	1412
Interleukin-4 (IL-4)	1227	1217	1413
Interleukin-5 (IL-5)	1228	1218	1414
Interleukin-6 (IL-6)	1258	1257	1415
Interleukin-8 (IL-8)	1229	1219	1416
Interleukin-10 (IL-10)	1222	1212	1417
Interleukin-12 (IL-12p70)	1223	1213	1421
Interleukin-13 (IL-13)	1224	1214	1422
Interferon-gamma (IFN-γ)	1221	1271	1418
TNF-alpha (TNF-α)	1230	1220	1419
GM-CSF	1256	1255	1420

PANELS

403025 Th1/Th2 Panel (Serum)
IFNγ, IL-2, IL-4, IL-5, IL-10, IL-12p70, IL-13
403027 Pro-Inflammatory Panel (Serum)
IL-1β, TNF-α, IL-6, IL-8
403026 Th1/Th2 Panel (Plasma)
IFNγ, IL-2, IL-4, IL-5, IL-10, IL-12p70, IL-13
403028 Pro-Inflammatory Panel (Plasma)
IL-1β, TNF-α, IL-6, IL-8

Specimen Requirement: 1 mL of plasma, serum or other, freeze immediately. If using OTHER specify specimen type on test request form.

Handling & Transport: Specimens should be frozen and shipped via overnight courier with dry ice.

Must state specimen type when choosing OTHER category test codes (ie, spinal fluid, pleural fluid, etc.)

Type: _____

Patient ID#: _____ Physician: _____

Patient Name: _____

LAST

FIRST

DOB: ___/___/___ Age: _____ Sex: F M Spec. Date ___/___/___ Draw Time: _____ Serum
 Plasma
 Other _____Bill TO: Physician* Hospital/Lab Medicare Primary** Part B only: include copy of card

Medicare ID #** _____

 Prepayment Check Enclosed MasterCard/Visa/American Express

Credit Card# _____ Exp. Date: ___/___/___ Sec Code _____

Cardholder Signature _____ Print Cardholder Name _____

Name (Parent or Guardian): _____

Patient Address: (Medicare or Prepayment) _____

Phone: (____) _____ Work: (____) _____

It is my medical judgment that the testing marked on this test request form is medically necessary and the patient records in our office document the need for this testing. Tests in panels can be ordered individually.
Physician (please print) _____

Signature of Ordering Physician or Designate _____

The ICD-9 codes for the requested testing on this patient are following: _____

Date of Evaluation _____ DX/ICD-9 Code _____ UPIN# _____ NPI # _____

*New York law prohibits Laboratories from billing NY Physicians for services

** Medicare Information Required (Please refer to the Medicare Part B-Policy on *In Vitro* Allergen Specific IgE Testing)

3