Ocular Immunology Laboratory, Oregon Health & Science University
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 # (leave blank): **OI18-**	
OHSU MRN (leave blank):	Serum/Plasma (ml)
Patient Last Name:	First Name:
Date of Birth:	Sex:
Date Collected:	Date Received:
REFERRING LABORATORY/PHYSICIAN Name:	Mayo Clinic Laboratories
Street:	3050 Superior Drive NW
City: Rochester	State: MN Zip: 55901 Country:
Phone: 1-800-533-1710	Fax: 507-538-5340
Referring Physician Name:	
IDC-10 Diagnosis Code:	Date of Onset:

TEST REQUESTED (check the box on the left)

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

CLINICAL HISTORY AND FINDINGS (Provide the appropriate information or include in an accompanying letter)