

**Neuroblastoma Reference Laboratory: IMMUNOCYTOLOGY
SPECIMEN TRANSMITTAL FORM**

Childrens Hospital Los Angeles

Laboratory use only

Specimen no: _____
Record no: _____
Processed: yes / no
Entered: _____

A Specimen Transmittal Form must accompany every specimen. This form must be completely filled out.

**All specimens must contain the patient's full name and one other patient identifier.
The two patient identifiers must be the same on this form and the specimen container.**

Specimen Identifiers (patient name *plus* one other required)

LAST NAME _____ FIRST NAME _____ MIDDLE INIT. _____
Birth Date (mm/dd/yy): _____ Medical Record Number: _____
COG/CCG Registration Number: _____ POG Registration Number: _____
NANT Registration Number: _____

Diagnosis: _____ Diagnosis Date (mm/dd/yy): _____ Stage: __IV__
Is Patient Enrolled on a Study? (circle): **YES / NO** Study: _____ Study: _____
Study: _____ Study: _____

Physician Information (must be completed to receive test result):

Treating Physician: _____ Phone: _____
email: _____ Fax (required): _____
Other Physician: _____ Phone: _____
email: _____ Fax (required): _____
Contact Person: _____ Phone: _____
email: _____ Fax (required): _____
Institution: _____
Address: _____

Specimen Information:

Type (circle) Date obtained (mm/dd/yy)
Bone Marrow _____ Fresh / Frozen (circle)
Blood _____ Fresh / Frozen (circle)
PBSC _____ Fresh / Frozen (circle)

Billing Information:

Institution _____
Address: _____ Phone: _____
_____ Fax (required): _____

Ship Specimen To:

Robert C. Seeger, M.D.
Neuroblastoma Reference Laboratory
Smith Research Tower, Room 509, MS-57
4650 Sunset Blvd.
Los Angeles, CA 90027-6016 Phone: **323-669-5630**

Contact Person: Peter Wakamatsu
Phone: **323-669-5630** FAX: **323-671-3889** email: **pwakamatsu@chla.usc.edu**