OKLAHOMA MEDICAL RESEARCH FOUNDATION
CLINICAL IMMUNOLOGY LABORATORY

825 N.E. 13th Street, MC-109
Oklahoma City, OK 73104
Clinical Lab: (405) 271-7771
Myositis Lab: (405) 271-7397
Billing: (405) 271-3173

*****All tests require 1-2mL serum at room temperature unless special conditions are indicated in **[brackets]** *****

OMRF Clinical Immunology (allow 5-7 working days for results)

❑	Lupus Screen (Reichlin Profile)	$155.00
	❑ ANA by HEP-2 (+$20.00 for titer if positive)	$30.00
	❑ Anti-dsDNA by Crithidia (+$20.00 for titer if positive)	$50.00
	❑ Extractable Nuclear Antibody responses by precipitin for SLE, Sjogren's, Myositis, Scleroderma (Ro, La, Sm, nRNP, P, Jo-1, Mi-2, PmScl)	$75.00
❑	Anti-CCP by ELISA	$80.00
❑	Anti-SCL70 (anti-topoisomerase) by precipitin	$85.00
❑	ANCA Profile - ANCA by IFA, PR3 and MPO by ELISA	$100.00
❑	Cryoglobulins **[No SST, 37°C until separated]**	$30.00
	If positive, quantitation and characterization (anti-IgG, IgM, IgA, Kappa, Lambda)	$65.00
❑	Dense Fine Speckled 70 by ELISA (DFS70)	$35.00
❑	Anti-phospholipid/anti-cardiolipin (aCL) by ELISA (IgG, IgM, IgA)	$125.00

OMRF Myositis Laboratory (allow 6-8 weeks for results)

❑	Traditional Myositis Autoantibody Profile Jo-1, PL7, PL12, EJ, OJ, SRP, Mi-2, PMScl, Ku, Ro60, U1RNP, U2RNP	$350.00
❑	Comprehensive Myositis Autoantibody Profile Jo-1, PL7, PL12, EJ, OJ, SRP, Mi-2, PMScl, Ku, Ro60, U1RNP, U2RNP, p155/140 (TIF1g), MJ (NXP2), caDM140 (MDA5)	$490.00
❑	Scleroderma Autoantibody Profile anti-Centromere by IFA, anti-SCL-70 by Immunodiffusion, IPP for anti-RNA Polymerase, U3RNP, PM-SCL, U1RNP, KU, TH/TO	$280.00
	Individual Autoantibody Testing by Immunoprecipitation-blotting ❑ p155/140 (TIF1g) ❑ MJ (NXP2) ❑ caDM140 (MDA5)	$200.00/ea
	Individual Autoantibody Testing by Immunoprecipitation ❑ Jo-1 ❑ OJ ❑ Ku ❑ Th/To ❑ PL7 ❑ SRP ❑ Ro60 ❑ U3RNP ❑ PL12 ❑ Mi-2 ❑ U1RNP ❑ RNA-poly (1,2,3) ❑ EJ ❑ PMScl ❑ U2RNP	$150.00/ea

Specimen Collection Date: _____ / _____ / _____

Patient Name: _____
LAST FIRST MI

Diagnosis: _____ DOB: _____ / _____ / _____ Sex: M F

Pt. Facility# _____ Ins Pol#: _____

MD Name: _____ Ins Grp#: _____

NPI: _____ Medicare: _____

Phone: _____ Bill To: _____

Physician/Facility Address/FAX NUMBER

_____

_____

_____

Patient Address

_____

_____

_____

*****PLEASE SEND FRONT AND BACK COPY OF PATIENT'S INSURANCE CARD*****