BloodCenter of Wisconsin does NOT bill patients or their insurance. Call 800-245-3117 ext. 6250 for your Client#.

Person Completing Requisition	
Institution	Client#
Dept	Physician/Provider
Address	
City	ST ZIP
Phone (Lab)	Phone/Email (Provider)

BLOODCENTER of WISCONSIN™
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Hematology Genetics Test Requisition Form
Phone 800-245-3117 x 6250 / Fax (414) 937-6206

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? Yes ☐ No ☐ If yes, please complete information on the reverse.

Special Reporting Requests:	**PO#:**

PATIENT INFORMATION

Last Name:	**First Name:**	**MI:**	**DOB:**
MR#:	**Accession#:**	**Draw Date:**	**Draw Time:**

Sex: ☐ Male ☐ Female ☐ Other Karyotype: _____ **Is patient currently pregnant?** ☐ Yes ☐ No Due date: _____

Has patient had an allogeneic stem cell transplant?
☐ Yes ☐ No If yes, send pre-transplant extracted DNA sample

Has patient had a blood transfusion in the last 2 weeks?
☐ Yes ☐ No Date and type of transfusion: _____

Specimen Type: ☐ ACD Blood ☐ Buccal Swabs ☐ EDTA Blood ☐ Bone Marrow ☐ DNA ☐ Sodium Heparin Blood ☐ Other _____

Fetal Specimen Type: ☐ Amniotic Fluid ☐ Cultured Amniocytes ☐ CVS ☐ Cultured CVS ☐ DNA ☐ Other _____

PATIENT HISTORY (Necessary for optimal interpretation of test results and recommendations)

Ethnic Background (check all that apply):
☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian ☐ Other_____

Clinical Diagnosis:

Relevant Clinical Presentation and Laboratory Findings (attach case notes if available):

Family history of disorder? ☐ Yes ☐ No If yes, Please describe in detail below. Attach pedigree if available.

TEST ORDERS (see reverse side for sample requirements and gene lists)

Hematology Genetics Panels

☐ aHUS Genetic Evaluation (1200) *15 genes*	☐ Congenital Neutropenia Panel (4845) *23 genes*
☐ Autosomal Dominant Thrombocytopenia Panel (4865) *14 genes*	☐ Fibrinolytic Disorder Panel (4860) *8 genes, one deletion/duplication*
☐ Coagulation Disorder Panel (4815) *19 genes, one targeted variant*	☐ Inherited Thrombocytopenia Panel (4840) *23 genes*
☐ Comprehensive Bleeding Disorder Panel (4825) *51 genes*	☐ Platelet Function Disorder Panel (4835) *31 genes*
☐ Comprehensive Platelet Disorder Panel (4830) *43 genes*	☐ Thrombosis Panel (4820) *12 genes*

☐ Custom Blood Disorder Panel (4850) (Two gene minimum, 10 gene maximum. If greater than 10 genes desired, please call 800-245-3117 ext 6250)
Genes:_____

Single Gene and Targeted Sequence Analysis (additional tests available, see catalog)

Hemophilia		**Thrombotic Disorders**
☐ Factor VIII (*F8*) Sequence Analysis (1404)		☐ *ADAMTS13* Sequence Analysis (1300) ☐ Factor V Leiden (1035)
☐ Factor VIII (*F8*) Severe HA Analysis Reflex (1403)		☐ Prothrombin Gene Mutation (1024)
☐ Factor VIII (*F8*) Inversion Analysis (1402) ☐ Intron 1 (1401) ☐ Intron 22 (1400)		**von Willebrand Disease**
☐ Factor IX (*F9*) Sequence Analysis (1405)		☐ *VWF* Full Gene Sequencing (1395) (exons 1-52)
Platelet and Neutrophil Disorders		☐ *VWF* D1472H Ristocetin-Binding Polymorphism (1301)
☐ Bernard Soulier Sequence Analysis (1290) (*GPIBA, GPIBB, GP9)*		☐ VWD Type 1C (Clearance) Sequence Analysis (1389) (*VWF* exons 27,28,34,37)
☐ *ELANE* Sequence Analysis (5107)	☐ *RUNX1* Sequence Analysis – Inherited (5763)	☐ VWD Type 2A/2B Reflex Sequence Analysis (1388) (*VWF* exon 28, if indicated exons 6, 7, 11-16, 19, 22, 26, 51-52)
☐ *HAX1* Sequence Analysis (5762)	☐ *MYH9* Sequence Analysis – Inherited (5765)	☐ VWD Type 2M Exon 28 Sequence Analysis (1284) (*VWF* exon 28)
☐ *WAS* Sequence Analysis (5761)	☐ *MPL* Sequence Analysis (5760)	☐ VWD Type 2N Sequence Analysis (1288) (*VWF* exons 17-21, 24-27)
Familial Testing		☐ VWD Platelet-Type Sequence Analysis (1289) (*GPIBA)*
☐ Targeted Familial Variant Analysis (4970) Gene: _____ Exon:_____ Variant:_____ Index name: _____ Relationship to Index:_____		**Single and Other Genetic Test Orders** ☐ Single Gene Sequence Analysis (4855) : _____ (if more than one, please use Custom Blood Disorder Panel above)

Deletion/Duplication Analysis	**Maternal Cell Contamination (MCC)**	**BCW Use Only**	
☐ aCGH Deletion/Duplication Analysis (4800) Gene(s): _____	☐ Maternal sample sent for MCC only ☐ Maternal sample sent for MCC and testing	____ EDTA ____ ACDA ____ Amnio ____ CVS ____ Heparin ____ BM	Opened By _____ Evaluated By _____

SAMPLE REQUIREMENTS Label samples clearly with full name of individual, date, and time drawn.

Source	Specimen Type	Volume Required
Parental/Patient/Pediatric	Whole Blood (lavender top)	3-5 mL
	Bone marrow (lavender top)	2-5 mL
	Buccal Swabs	3-4 swabs
	High Quality DNA	≥1µg of DNA at ≥50ng/µL
Fetal – MCC Studies recommended	Amniotic Fluid	7-15 mL
	CVS	5-10mg
	Cultured Amniocytes or CVS	Two T25 flasks ($2x10^6$ minimum)

SHIPPING REQUIREMENTS

Ship on an ice pack or at room temperature, protect from freezing. Place the specimen and the requisition into plastic bags and seal. Insert into a Styrofoam container, seal and place into a sturdy cardboard box, and tape securely. Ship the package in compliance with your overnight carrier guidelines. Label with the following address:

Client Services/Diagnostic Laboratory BloodCenter of Wisconsin
638 N. 18th St. Milwaukee, WI 53233-2121
Please call the laboratory (800-245-3117 ext 6250) for advice if you will ship samples near a major holiday

Verification of Informed Consent for New York State Patients. (A more extensive informed consent form is available upon request.)

No tests other than those authorized will be performed on genetic samples. The sample will be destroyed not more than 60 days after the sample was taken, unless a longer period of retention is expressly authorized in the consent.

Physician I am a physician counseling the patient named on the front side of this requisition. I have obtained the informed consent of the patient for each genetic test(s) ordered above and authorize the testing of the enclosed specimen(s).

Signature of Physician _____ Date _____

Patient: I have been informed of the nature and limitations of each genetic test requested on this form and give my permission to the above named physician to send my specimen(s) to BloodCenter of Wisconsin for testing. I authorize BloodCenter of Wisconsin to report the results to the above named physician or a designated diagnostic center.
Name of diagnostic center: _____

Signature of Patient _____ Date _____

If patient is making payment, please select payment type and submit a completed Patient Billing Form:

☐ Check (Payable to BloodCenter of Wisconsin) ☐ Credit Card

*Credit card website if hyperlink not working: https://www.bcw.edu/cs/groups/public/documents/documents/bf9n/zw5l/~edisp/dl_pt_bill_general.pdf

If testing is for outpatient Medicare enrollee or Wisconsin Medicaid recipient, please fill out form below:

MEDICARE (OUTPATIENT) AND Wisconsin MEDICAID BILLING INFORMATION
BloodCenter of Wisconsin will bill the institution directly unless testing is performed on an OUTPATIENT Medicare enrollee or a Medicaid recipient from WI.

Medicare # _____
Railroad Retiree # _____
Medicaid # _____ (Wisconsin only)
Patient's Address _____
City _____ State _____ Zip _____
Diagnosis _____ Diagnosis Code _____
Referring Physician's Full Name _____
Referring Physician's Provider # (NPI#) _____ Physician's Phone Number

HEMATOLOGY GENETICS PANEL INFORMATION

Panel Name	Genes Tested
aHUS Genetic Evaluation	*ADAMTS13, C3, C4BPA, C4BPB, CFB, CFHR1, CFHR3, CFHR4,CFHR5, DGKE, CFH, CFI, LMNA, MCP(CD46), THBD*
Autosomal Dominant Thrombocytopenia Panel	*ACTN1, ANKRD26, CYCS, ETV6, FLI1,GFI1B, GP1BA, GP1BB, GP9, ITGA2B, ITGB3, MYH9, RUNX1, TUBB1*
Coagulation Disorder Panel	*F2, F5, F7, F8, F9, F10, F11, F13A1, F13B, FGA, FGB, FGG, GGCX, LMAN1, MCFD2, SERPINA1, SERPINE1, SERPINF2, VKORC1, VWF*
Comprehensive Bleeding Disorder Panel (Coagulation Disorder and Platelet Function Disorder Panels combined)	*ANO6, AP3B1, BLOC1S3, BLOC1S6, DTNBP1, F2, F5, F7, F8, F9, F10, F11, F13A1, F13B, FERMT3, FGA, FGB, FGG, FLI1, GATA1, GFI1B, GGCX, GP1BA, GP1BB, GP6, GP9, HPS1, HPS3, HPS4, HPS5, HPS6, ITGA2B, ITGB3, LMAN1, LYST, MCFD2, NBEAL2, P2RY12, PLA2G4A, PRKACG, RASGRP2, RUNX1, SERPINA1, SERPINE1, SERPINF2, STIM1, TBXA2R, VIPAS39, VKORC1, VPS33B, VWF*
Comprehensive Platelet Disorder Panel (Inherited Thrombocytopenia and Platelet Function Disorder Panels combined)	*ACTN1, ANKRD26, ANO6, AP3B1, BLOC1S3, BLOC1S6, CYCS, DTNBP1, ETV6, FERMT3, FLI1, GATA1, GFI1B, GP1BA, GPIBB, GP6, GP9, HOXA11, HPS1, HPS3, HPS4, HPS5, HPS6, ITGA2B, ITGB3, LYST, MPL, MYH9, NBEAL2, P2RY12, PLA2G4A, PRKACG, RASGRP2, RBM8A, RUNX1, STIM1, STXBP2, TBXA2R, TUBB1, VIPAS39, VPS33B, WAS, WIPF1*
Congenital Neutropenia Panel	*AP3B1, CSF3R, CXCR4, ELANE, G6PC3, GATA1, GATA2, GFI1, HAX1, JAGN1, LAMTOR2, LYST, RAB27A, RAC2, SBDS, SLC37A4, TAZ, TCIRG1,USB1, VPS13B, VPS45, WAS, WIPF1*
Fibrinolytic Disorder Panel	*F13A1, F13B, FGA, FGB, FGG, PLAU, SERPINA1, SERPINE1, SERPINF2*
Inherited Thrombocytopenia Panel	*ACTN1, ANKRD26, CYCS, ETV6, FLI1, GATA1, GFI1B, GP1BA, GP1BB, GP9, HOXA11, ITGA2B, ITGB3, MPL, MYH9, NBEAL2, PRKACG, RBM8A, RUNX1, STXBP2, TUBB1, WAS, WIPF1*
Platelet Function Disorder Panel	*ANO6, AP3B1, BLOC1S3, BLOC1S6, DTNBP1, FERMT3, FLI1, GATA1, GFI1B, GP1BA, GP1BB, GP6, GP9, HPS1, HPS3, HPS4, HPS5, HPS6, ITGA2B, ITGB3, LYST, NBEAL2, P2RY12, PLA2G4A, PRKACG, RASGRP2, RUNX1, STIM1, TBXA2R, VIPAS39, VPS33B*
Thrombosis Panel	*ADAMTS13, F2, F5, FGA, FGB, FGG, HRG, KNG1, PROC, PROS1, SERPINC1, THBD*
Custom Blood Disorder Panel	Selected any genes from established panels. Two gene minimum, 10 gene maximum. If greater than 10 genes desired, please call 800-245-3117 ext 6250