For consultation regarding genetic test selection, please call 800-245-3117 (x6250) to speak to our laboratory genetic counselors.

Versiti 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)

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 the **beneficiary form** located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition.

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 _____

****Please complete patient history on page 2****

TEST ORDERS

Hematology Genetics Panels (for additional panel details, visit versiti.org/HG)

☐ 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*) Inversion Analysis (1402) *Introns 1 and 22*		☐ *ADAMTS13* Sequence Analysis (1300)	☐ Factor V Leiden (1035)
☐ Factor VIII (*F8*) Severe HA Analysis Reflex (1403) *inversion, reflex to sequencing*		☐ Prothrombin Gene Mutation (1024)	
☐ Factor VIII (*F8*) Sequence Analysis (1404)		**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:_____ ☐ Factor VIII (F8) Inversion Analysis ☐ Intron 22 (1400) ☐ Intron 1 (1401)		**Single and Other Genetic Test Orders** ☐ Single Gene Sequence Analysis (4855) : - *(If more than one gene is considered, please contact our client services team at **800-245-3117 ext. 6250** to determine if a custom panel is a more cost effective option.)*	

Deletion/Duplication Analysis	Maternal Cell Contamination (MCC)	Versiti 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 _____

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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.	

VERIFICATION OF INFORMED CONSENT

It is recommended that healthcare providers obtain a signed informed consent from the patient when genetic testing is ordered. By signing the informed consent, the patient agrees that that they have received and understand the indications and implications of the genetic test and are voluntarily agreeing to have the test performed. In some states, informed consent is **required** by existing laws and regulations. Versiti recommends that ordering healthcare providers verify their state laws and regulations regarding informed consent for genetic testing. An informed consent form may be available from your institution or one can be found at http://www.versiti.org/hg under *forms.* Information regarding a general description of the test, purpose, sensitivity, analytical limitations, and the features and genetics of the condition(s) is also available in the Versiti test catalog.

New York State patients: New York state healthcare providers are required to provide verification that informed consent (complying with New York State Department of Health Genetic Testing Standard 5 [GT S5] and New York State Civil Rights Law, Section 79-l) has been obtained from their patient. In order for genetic testing to be performed in our laboratory, please sign the verification below or submit a signed informed consent form. The sample will be destroyed not more than 60 days after the sample was obtained, unless a longer period of retention is expressly authorized in the consent

Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test(s) ordered above and I authorize the testing of the enclosed specimen(s). I understand that no tests other than those authorized will be performed on genetic samples.

_____ _____

Signature of healthcare provider 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

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:

Versiti Wisconsin – Molecular Diagnostics
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

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

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