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)	
Special Reporting Requests:	**PO#:**

Molecular Diagnostics Laboratory
Phone 800-245-3117 x 6250 / Fax (414) 937-6206

MEDICARE

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? **Yes ☐** **No ☐**
If yes, please complete and attach our beneficiary form located at www.versiti.org/medical-professionals/products-services/requisitions

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. Attach pedigree and additional information if available.

TEST ORDERS (see reverse side for sample requirements)

ENGRAFTMENT / CHIMERISM

TRANSPLANT INFORMATION:
☐ Bone Marrow ☐ Solid Organ ☐ Other_____
Transplant Date:_____

Pre-Transplant Testing

☐ For Recipient Sample (4020) (Provide donor name)
Donor Name:_____
☐ For Donor Sample (4040) (Provide recipient name)
Recipient Name:_____
☐ For Twin Zygosity Analysis (4060) (Provide donor name)
Donor Name: _____
☐ For Twin Zygosity Analysis (4070) (Provide recipient name)
Recipient Name: _____

Post-Transplant Testing

☐ **STAT Testing** (Results in 48 hours/72 hours if sorted cells)
☐ Chimerism on blood or bone marrow (4199)

Prepare Sorted Cells, Perform Chimerism
☐ CD3 & CD33 cells (4091/4199)
☐ CD19 cells (4097/4199)
☐ CD56 cells (4098/4199)
☐ CD3 cells (4093/4199)
☐ CD3 & CD33 & CD56 cells (4107/4199)
☐ CD19 & CD56 cells (4106/4199)
☐ Prepare MNC, chimerism (4092/4199)
☐ Prepare buffy coat, chimerism (4094/4199)

ERYTHROID CHIMERISM

☐ Erythroid Chimerism (4250)
Donor Genotype_____**☐AA ☐AS (Required)**
Recipient Genotype_____**☐SS ☐AS (Required)**

BCR-ABL TESTING

PURPOSE OF TESTING:
☐ Diagnosis ☐ Monitoring Therapy

☐ BCR-ABL Quantitative Analysis (4502)
☐ BCR-ABL Breakpoint Identification
Order with BCR-ABL Quant (4504)
☐ BCR-ABL Kinase Mutation Analysis (4507)

PRENATAL GENOTYPING

LMP Date:_____ Gestational Age: _____
Sample(s) submitted from (check allthat apply): (Analysis of parental samples is highly recommended)
☐ Mother ☐ Father ☐ No Parental Sample
Father's Name:_____
Father's DOB: _____

RED CELL GENOTYPING

For Hemolytic Disease of Fetus and Newborn
Check appropriate system and complete serological information if known

☐ RhC/c (4445) ☐ RhD Zygosity(4475) ☐ RhD (4455)
☐ $Fy^{a/b}$ (Duffy)(4405) ☐ RhE/e (4465) ☐ K1/K2 (Kell)(4415)
☐ $Jk^{a/b}$ (Kidd)(4425) ☐ M/N(4435) ☐ S/s (4485)

Serology Typing

Maternal/Patient serological type _____

Paternal serological type _____

MATERNAL CELL CONTAMINATION

☐ Maternal sample sent for **MCC** only

☐ Maternal sample sent for **MCC** and genotyping

HEMOCHROMATOSIS

☐ Hemochromatosis (4600)

SICKLE CELL DISEASE

☐ Hemoglobin SC Mutation Analysis (4624)

Versiti Use Only

___EDTA____BM
___Amnio____ACDA
___ACDB____Clot
___Heparin____CVS
___Other _____

Opened By ____

Evaluated By ____

DRAWING INSTRUCTIONS: Tubes must be individually labeled with **FULL NAME OF INDIVIDUAL, DATE AND TIME OF DRAW**. **Samples will be accepted from 8:00 A.M. to 5:00 P.M. Monday through Friday and Saturday morning.** Emergency testing **MUST** be arranged through the laboratory by calling 1-800-245-3117, ext. 6218.

Test	Sample Type	Store and Ship
BCR-ABL Quantitative Analysis BCR-ABL Kinase Mutation Analysis BCR-ABL Breakpoint Identification Erythroid Chimerism	3-5 mL EDTA Bone Marrow (lavender top) OR 10 mL EDTA Whole Blood (lavender top)	Room temperature via an overnight courier. Samples must be received within 48 hours of being drawn.
Hemoglobin SC Mutation Analysis Prenatal Testing Red Cell Antigen RhD Zygosity Maternal Cell Contamination	**FETAL**: 7-15 mL Amniotic Fluid or 5-10 mg CVS, backup culture of Amniocytes or CVS is highly recommended; Two T25 flasks Cultured Amniocytes or CVS (2x10^6 minimum) **PARENTAL & PATIENTS**: 3-5 mL EDTA whole blood (lavender top). Maternal sample for maternal cell contamination 1µg DNA (25ng/µl and 25µl)	Room temperature.
Engraftment/Chimerism	**PRE-TRANSPLANT:** 3-5 mL EDTA (lavender top) whole blood or bone marrow OR 4-8 Buccal Swabs **POST-TRANSPLANT:** 3-5mL EDTA (lavender top) whole blood or bone marrow	Room temperature.
Cell Sort Enrichment CD3, CD19, CD33, CD56	4-7 mL Na Heparin (green top) whole blood per cell type sort. (Preferred) OR 4-7mL EDTA (lavender top) OR 4-7 mL ACDA (yellow top) whole blood per cell type sort. OR 3-5 mL bone marrow per cell type sort.	Room temperature. Samples must be received within 24 hours of draw and may be drawn Monday through Thursday for delivery Tuesday through Friday.
Hemochromatosis	3-5 mL EDTA (lavender top) whole blood	Room temperature.
Tissue	50-150 mg tissue (Call lab prior to shipping.)	Freeze and ship on dry ice or place in transport media and ship on ice or cold pack.

Blood samples should be shipped by overnight carrier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations.

Shipping address: Versiti Wisconsin – Molecular Diagnostic Laboratory
638 N. 18th Street
Milwaukee, WI 53233
Phone: (414) 937-6250

Label Box: Refrigerate, Room Temperature, or Frozen (whichever is appropriate)

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