

PATIENT INFORMATION		
Name: <i>(Last, First, Middle)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Address:	Home Phone:	Work Phone:
City: State: Zip:	Lab #	Hospital #
REFERRED BY		
Physician: <i>(print)</i>	Facility:	Phone:
I attest that this patient has been informed and has given consent for the test(s) I have ordered under applicable law.	Address:	
Physician/Authorized Signature: _____	City:	State: Zip:
BILLING		
<input type="checkbox"/> CLIENT BILL * <input type="checkbox"/> INSURANCE	<i>* Attach billing information including a copy of the patient's face sheet plus a copy of the insurance card(s) for billing purposes.</i>	
<input type="checkbox"/> SELF-PAY * <input type="checkbox"/> MEDICARE/MEDICAID		
SPECIMEN INFORMATION (DO NOT FREEZE - ALL SPECIMENS MUST BE LABELED)		
Date of Collection: _____ Time of Collection: _____	<input type="checkbox"/> Amniotic Fluid	<input type="checkbox"/> Peripheral Blood
Status: <input type="checkbox"/> Pre-Transplant <input type="checkbox"/> Post-Transplant	<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Products of Conception
Donor: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Autologous	<input type="checkbox"/> Chorionic Villi	<input type="checkbox"/> Tissue, Source: _____
WBC: _____ Blasts: _____	<input type="checkbox"/> Extracted DNA	<input type="checkbox"/> Fixed Pellets
REFERRING DIAGNOSES (CHECK ALL THAT APPLY)		
Oncology	Prenatal/Postnatal	
ICD-10: _____	ICD-10: _____	
<input type="checkbox"/> Acute Lymphoblastic Leukemia (ALL)	<input type="checkbox"/> Multiple Myeloma (MM)	<input type="checkbox"/> Advanced Maternal Age
<input type="checkbox"/> Acute Myeloid Leukemia (AML)	<input type="checkbox"/> Myelodysplastic Syndrome (MDS)	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Acute Promyelocytic Leukemia (APL)	<input type="checkbox"/> Myeloproliferative Neoplasm (MPN)	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Anemia	<input type="checkbox"/> Non-Hodgkin Lymphoma, B-Cell	<input type="checkbox"/> Cystic Hygroma
<input type="checkbox"/> Chronic Myelogenous Leukemia (CML)	<input type="checkbox"/> Non-Hodgkin Lymphoma, T-Cell	<input type="checkbox"/> Developmental Delay
<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL)	<input type="checkbox"/> Pancytopenia	<input type="checkbox"/> Multiple Congenital Anomalies
<input type="checkbox"/> Hairy Cell Leukemia (HCL)	<input type="checkbox"/> Plasma Cell Neoplasm	<input type="checkbox"/> Increased Risk of Trisomy 18
<input type="checkbox"/> Hodgkin Lymphoma	<input type="checkbox"/> Polycythemia	<input type="checkbox"/> Increased Risk of Trisomy 21
<input type="checkbox"/> Leukocytosis	<input type="checkbox"/> Thrombocytosis	<input type="checkbox"/> Fetal Demise
<input type="checkbox"/> Leukopenia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Missed Abortion
<input type="checkbox"/> MGUS	<input type="checkbox"/> Thrombocythemia	<input type="checkbox"/> Spontaneous Abortion
		<input type="checkbox"/> Recurrent Pregnancy Loss
		<input type="checkbox"/> Trisomy: _____
		<input type="checkbox"/> Other: _____
REQUESTED TESTING		
PCR:		
<input type="checkbox"/> BCR-ABL1 p210 t(9;22) (Quantitative)	<input type="checkbox"/> B-Cell Clonality Assessment	
<input type="checkbox"/> BCR-ABL1 p190 t(9;22) (Quantitative)	<input type="checkbox"/> T-cell Gamma Clonality Assessment	
<input type="checkbox"/> IGHV Hypermutation Analysis	<input type="checkbox"/> T-cell Beta Clonality Assessment	
<input type="checkbox"/> JAK2 V617F	<input type="checkbox"/> Thrombophilia Panel (Factor II, Factor V, MTHFR)	
NEXT-GENERATION SEQUENCING:		
<input type="checkbox"/> Myeloid Complete Molecular Profile* (ABL1, ASXL1, BRAF, CALR, CBL, CEBPA, CSF3R, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MPL, NPM1, NRAS, RUNX1, SETBP1, SF3B1, SRSF2, TET2, TP53, U2AF1)		
<input type="checkbox"/> MDS Molecular Profile (ASXL1, EZH2, DNMT3A, RUNX1, SF3B1, SRSF2, TET2, TP53, U2AF1)		
<input type="checkbox"/> MPN Molecular Profile (ABL1, CALR, CSF3R, EZH2, JAK2, MPL, SETBP1)		
<input type="checkbox"/> AML Molecular Profile* (ASXL1, CBL, CEBPA, CSF3R, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, MPL, NPM1, NRAS, RUNX1, SETBP1, SF3B1, SRSF2, TET2, TP53, U2AF1)		
*FLT3, a component of the Myeloid Complete Molecular Profile and the AML Molecular Profile, is sent out as a referral test. If you choose not to include FLT3, please check the following box. <input type="checkbox"/> FLT3, do not include		
MICROARRAY:		
<input type="checkbox"/> CANCER MICROARRAY Preferred test for detecting DNA copy number changes and loss of heterozygosity (LOH) in leukemias/lymphomas at time of diagnosis.		
<input type="checkbox"/> PRENATAL MICROARRAY		
<input type="checkbox"/> POST NATAL MICROARRAY		

PATIENT PREPARATION

Refer to collection facility's procedures for patient preparation requirements.

SPECIMEN COLLECTION

Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Amniotic Fluid	10 mL of whole fluid	Sterile Centrifuge Tube	Room Temperature: 20-22°C	Do Not Freeze
Bone Marrow	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA Tube	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to Prevent Clots
Chorionic Villi	>10 mg of Villi	Sterile Centrifuge Tube with Transport Media	Room Temperature: 20-22°C	Do Not Freeze
Extracted DNA	2 µg DNA	DNA RNase-free Microcentrifuge Tube	Refrigerated Temperature: 2-8°C	
Fixed Pellets	Pellet must be visible	Sterile Centrifuge Tube With 3:1, Methanol: Acetic Acid	Refrigerated Temperature: 2-8°C	Pellet should not be older than 1 week
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA Tube	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to Prevent Clots
Products of Conception	>10 mg of Villi, Placenta, Placental Membrane, or Fetal Tissue	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Do Not add Formalin

Special Instruction: Specimens for RNA based tests (PCR BCR/ABL1 p210 and p190) must be received in the lab within 72 hours of collection.

Isolated or Extracted Nucleic Acid Acceptance Policy: Genetics Associates, Inc. only accepts nucleic acid for clinical testing that was isolated or extracted in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

SPECIMEN COLLECTION AND TRANSPORTATION

- Clearly label each specimen with patient name and one other unique identifier such as date of birth or medical record number.
- Call Genetics Associates, Inc. at 615-327-4532 for pick-up in the greater Nashville area.
- Federal Express overnight shipment will be provided for all outlying areas.
- Mark the "Saturday Delivery" box on the FedEx air bill for all samples shipped on Friday.
- Send samples with a cold pack during warmer weather to ensure specimen integrity. (Use frozen cold pack for specimens requesting PCR)
- **Refer to the Genetics Associates website for complete specimen collection guide. www.geneticsassociates.com**

USE OF SPECIMENS

Genetics Associates, Inc. may retain patient samples (specimens) for validation, educational purposes and/or research. All patient information is maintained as confidential and secure. Any patient samples which are retained by Genetics Associates, Inc. are de-identified and all individually identifiable patient information is removed before samples are used for research.

By marking the box below, you may decline research use and it will not impact the services to you by Genetic Associates, Inc. diagnostic testing/reports. Unless you mark the box below, you consent to the use of your de-identified patient sample for the limited purposes described above.

I am checking this box to indicate that the sample may **NOT** be used for validation, educational purposes and/or research. Patient initials: _____

My Address is _____

My Telephone Number is _____ My email address is _____

Signature of Patient /Responsible Party **(Required)** _____ Date **(Required)** _____

Relationship to Patient **(Required)**