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™
PART OF VERSITI

Molecular Diagnostics Laboratory
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)

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 all that 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)

BCW 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	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.

Packages should be addressed to:

Client Services/Molecular Diagnostics Laboratory
BloodCenter of Wisconsin
638 North 18th Street
Milwaukee, WI 53233

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

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 _____

MEDICARE (OUTPATIENT) AND MEDICAID BILLING INFORMATION
BloodCenter of Wisconsin will bill the institution 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 NPI # _____ Physician's Phone # _____