

### Patient Information

Name: \_\_\_\_\_  
First name MI Last Name

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  Unknown  
mm dd yyyy

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Physician Identifier for Patient: \_\_\_\_\_

Please send sample and completed forms to:  
**Correlagen Diagnostics, Inc.**  
**307 Waverley Oaks Road, Suite 101, Waltham, MA 02452**  
**Phone: 866-647-0735 Fax: 781-647-0626**

### Sample Specifications

*Ship sample overnight at room temperature.*

Sample Collection: \_\_\_\_/\_\_\_\_/\_\_\_\_  A.M.  P.M.  
mm dd yyyy

Sample Drawn:  Inpatient  Outpatient

Sample Type (Check One):

Blood Sample (One ≥2 mL whole blood in lavender-top EDTA tube)

DNA (≥ 1 µg at 50 ng/µl in TE preferred)

Other: \_\_\_\_\_  
(Please contact client services before sending other sample types)

All samples must have a minimum of **two** identifiers.

### Referring Physician/Counselor Information

Institution Name: \_\_\_\_\_

Name: \_\_\_\_\_  
First MI Last

Medical Specialty: \_\_\_\_\_ NPI#: \_\_\_\_\_

Genetic Counselor's Name: \_\_\_\_\_

Address \_\_\_\_\_ Building/Suite \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Report should be:  Faxed  Emailed through Secure Server

**Physician/Counselor Statement:** I have explained DNA testing to this individual. I have addressed the limitations and benefits of testing and am witness to this patient's choice to have testing. I authorize this test.

\_\_\_\_\_  
Physician/Counselor Signature Date

### Indications for Testing

1. ICD-9 Code (required for billing): \_\_\_\_\_
2. Patient: Historical or current exam findings :  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Known family history of:  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Laboratory or other relevant findings:  
 \_\_\_\_\_  
 \_\_\_\_\_

### Immunology Test Selection (check all that apply)

<b>AUTOIMMUNE POLYGLANDULAR SYNDROME TYPE 1</b>	
<input type="checkbox"/> 110101 AIRE	
<b>CHRONIC GRANULOMATOUS DISEASE (CGD)</b>	
<input type="checkbox"/> 100801 CYBB	
<b>COMMON VARIABLE IMMUNODEFICIENCY SYNDROME (CVID)</b>	
<input type="checkbox"/> 100701 TNFRSF13B (TACI)	
<b>FAMILIAL MEDITERRANEAN FEVER</b>	
<input type="checkbox"/> 252797 MEFV	
<b>HYPOHIDROTIC ECTODERMAL DYSPLASIA (HED-ID)</b>	
<input type="checkbox"/> 100601 IKBKG (NEMO)	
<b>HYPER IgE SYNDROME (HIES)</b>	
<input type="checkbox"/> 120201 STAT3	
<b>HYPER IgM SYNDROME (HIGM)</b>	
<input type="checkbox"/> 100197 AICDA, UNG, CD40, CD40LG	<i>HIGM Individual Genes:</i> <input type="checkbox"/> AICDA <input type="checkbox"/> CD40 <input type="checkbox"/> UNG <input type="checkbox"/> CD40LG
<input type="checkbox"/> 100198 AICDA, UNG, CD40	
<input type="checkbox"/> 100199 AICDA, UNG	
<b>INTERFERON γ RECEPTOR DEFICIENCY</b>	
<input type="checkbox"/> 100999 IFNGR1, IFNGR2	<i>Interferon γ Individual Genes:</i> <input type="checkbox"/> IFNGR1 <input type="checkbox"/> IFNGR2
<b>SEVERE COMBINED IMMUNODEFICIENCY SYNDROME</b>	
<input type="checkbox"/> 100493 IL2RG, JAK3, RAG1, RAG2, IL7R, ADA, CD3D, CD3E, DCLRE1C (Artemis)	<i>SCID Individual Genes:</i> <input type="checkbox"/> ADA <input type="checkbox"/> CD3D <input type="checkbox"/> CD3E <input type="checkbox"/> DCLRE1C (Artemis) <input type="checkbox"/> IL2RG <input type="checkbox"/> IL7R <input type="checkbox"/> JAK3 <input type="checkbox"/> RAG1 <input type="checkbox"/> RAG2 <input type="checkbox"/> ZAP70
<input type="checkbox"/> 100494 IL2RG, JAK3, RAG1, RAG2, IL7R, ADA, CD3D, CD3E	
<input type="checkbox"/> 100495 IL2RG, IL7R, ADA	
<input type="checkbox"/> 100496 IL7R, CD3D, CD3E	
<input type="checkbox"/> 100498 RAG1, RAG2	
<input type="checkbox"/> 100492 RAG1, RAG2, DCLRE1C (Artemis)	
<input type="checkbox"/> 100499 IL2RG, JAK3	
<input type="checkbox"/> 100501 WAS	
<b>WISKOTT-ALDRICH SYNDROME</b>	
<input type="checkbox"/> 100501 WAS	
<b>X-LINKED AGAMMAGLOBULINEMIA (XLA)</b>	
<input type="checkbox"/> 100201 BTK	
<b>X-LINKED LYMPHOPROLIFERATIVE DISEASE (XLP)</b>	
<input type="checkbox"/> 101001 SH2D1A	

5.  Check if patient has had a Bone Marrow Transplant (BMT)
6. Ethnic Background:
  - African American  Ashkenazi Jewish  Asian
  - Caucasian  Hispanic  Other \_\_\_\_\_
7. Is this a test for a known familial mutation?  Yes  No  
 Familial Mutation: \_\_\_\_\_  
Gene (eg, MYH7) Variant (eg, c.746G>A)

If yes, was the family member (index patient) with the known mutation tested at Correlagen?

No, please attach a copy of the original index case report **(Required)**

Yes, please complete the following:

Patient's relation to index patient: \_\_\_\_\_

Index Patient Name: \_\_\_\_\_

Index Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Accession #: \_\_\_\_\_

Index patient has approved release of information for purposes of this test.

### Patient Informed Consent and Financial Acknowledgement

I choose to have testing at this time.  I decline testing at this time.

My signature below indicates that I have read (or had read to me) the information on the **second page** of this form pertaining to Patient Informed Consent and I understand this information.

I understand that I may have a financial responsibility associated with this testing, which is related to my insurance coverage and benefit plan and agree that I will make an effort to meet this financial obligation.

\_\_\_\_\_  
Signature of Patient/Parent or Legal Guardian Date

Cancellation requests will only be accepted if received before testing begins.

