

Patient Information

Name: _____
First name MI Last Name

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

Address/Country: _____

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 μ g at 50 ng/ μ l 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: _____

Complete Address/Country: _____

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:

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.

Test Selection (check all that apply)

PULMONOLOGY TESTING

CYSTIC FIBROSIS

160101 CFTR

UROLOGY TESTING

CONGENITAL BILATERAL ABSENCE OF VAS DEFERENS

150101 CFTR

NEPHROLOGY TESTING

RENAL CYSTS AND DIABETES SYNDROME

170201 TCF2

VON HIPPEL-LINDAU DISEASE

170101 VHL

OPHTHALMOLOGY TESTING

BARDET-BIEDL-SYNDROME

180199 BBS1, BBS2

Bardet-Biedl Syndrome:

BBS1 BBS2
 BBS10

VON HIPPEL-LINDAU DISEASE

180201 VHL

GASTROENTEROLOGY TESTING

CHRONIC PANCREATITIS

252794 CFTR, PRSS1, SPINK1

Pancreatitis:

CFTR PRSS1
 SPINK1

METABOLIC

GALACTOSEMIA

252816 GALT

WILSON'S DISEASE

252803 ATP7B

HEMATOLOGY

BETA THALASSEMIA

252823 HBB

ONCOLOGY

HNPCC

252844 MLH1, MSH2
 252860 MLH1, MSH2, MSH6
 252863 MLH1, MSH2, MSH6, PMS2

HNPCC:

MLH1 MSH6
 MSH2 PMS2

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.

Sender's Name: _____

Institution Name: _____

Complete Mailing Address: _____
(Including country) _____

Phone: _____ **Date:** _____

Indicate Type of Human Specimen: _____
(E.g. blood, DNA, buccal swab, or saliva)

Re: International Shipping of Human Specimens

To whom it may concern:

Please be advised that:

The items contained in this shipment under Airbill number _____ are samples of human
(insert Airbill number)
_____ from a patient that will be used for laboratory testing only.
(indicate type of specimen - blood, DNA, buccal swab, or saliva)

The specimens in the shipment are of "Human material containing no animal material or non-human primate material or other non-primate animal material."

We hereby declare that the human specimens contained in this shipment under Airbill number _____
(Insert Airbill Number)
"are not of tissue culture origin or any imported material that is a human vaccine in final dosage form."

We also state that the human specimens contained in this shipment under Airbill number _____
(insert Airbill number)
are non-cultured, non-recombinant, non-infectious, containing no animal content and/or bovine serum albumin.

We also declare that the human specimens contained in this package under Airbill number _____
(insert Airbill number)
have not had any previous testing.

This shipment is being sent to Correlagen Diagnostics, Inc., a clinical reference laboratory that performs genetic testing services for use by healthcare professionals in clinical practice.

If the above advisories do not meet with customs requirements, please advise. The telephone number is

(Sender's telephone #)

Sincerely,

(Sender's signature)