

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: _____

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 _____

Immunology Test Selection (check all that apply)

AUTOIMMUNE POLYGLANDULAR SYNDROME TYPE 1	
<input type="checkbox"/> 110101 AIRE	
CHRONIC GRANULOMATOUS DISEASE (CGD)	
<input type="checkbox"/> 100801 CYBB	
COMMON VARIABLE IMMUNODEFICIENCY SYNDROME (CVID)	
<input type="checkbox"/> 100701 TNFRSF13B (TAC1)	
HYPOHIDROTIC ECTODERMAL DYSPLASIA (HED-ID)	
<input type="checkbox"/> 100601 IKBKG (NEMO)	
HYPER IgE SYNDROME (HIES)	
<input type="checkbox"/> 120201 STAT3	
HYPER IgM SYNDROME (HIGM)	
<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	
INTERFERON γ RECEPTOR DEFICIENCY	
<input type="checkbox"/> 100999 IFNGR1, IFNGR2	<i>Interferon γ Individual Genes:</i> <input type="checkbox"/> IFNGR1 <input type="checkbox"/> IFNGR2
SEVERE COMBINED IMMUNODEFICIENCY SYNDROME	
<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	
WISKOTT-ALDRICH SYNDROME	
<input type="checkbox"/> 100501 WAS	
X-LINKED AGAMMAGLOBULINEMIA (XLA)	
<input type="checkbox"/> 100201 BTK	
X-LINKED LYMPHOPROLIFERATIVE DISEASE (XLP)	
<input type="checkbox"/> 101001 SH2D1A	

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 \geq 2 mL whole blood in lavender-top EDTA tube)
 DNA (\geq 1 μ g at 50 ng/ μ l in TE preferred)
 Other: _____
(Please contact client services before sending other sample types)

Indications for Testing

- ICD-9 Code (required for billing): _____
 - Test Patient: Historical or current exam findings :

 - Known family history of:

 - Laboratory or other relevant findings:

 - Ethnic Background:
 African American Ashkenazi Jewish Asian
 Caucasian Hispanic Other _____
 - Is this a test for a known familial mutation? Yes No
Familial Mutation: _____ Variant (eg, c.746G>A)
Gene (eg, MYH7)
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
 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 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.

