For consultation regarding genetic test selection, please call 800-245-3117 (x6250) to speak to our laboratory genetic counselors.

Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.

Person Completing Requisition	
Institution	Client#
Dept	Physician/Provider
Address	
City	ST ZIP
Phone (Lab)	Phone/Email (Provider)

Hematology Genetics Test Requisition Form
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 the **beneficiary form** located at www.versiti.org/medical-professionals/products-services/requisitions and submit with this requisition.

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 _____

Maternal Cell Contamination (MCC) ☐ Maternal sample sent for MCC only ☐ Maternal Sample sent for MCC and testing

Hematology Genetics Single Genes and Panels (for additional panel details, visit versiti.org/HG)

Select test from the menu below, followed by the order detail in BOX B. Box B must be completed for each order, unless otherwise noted.

☐ aHUS Genetic Evaluation (1200) *15 genes* **does not require Box B.*
☐ Autosomal Dominant Thrombocytopenia Panel (4865) *22 genes*
☐ Bernard-Soulier Syndrome Panel (4880) *3 genes*
☐ Coagulation Disorder Panel (4815) *19 genes, 1 targeted variant*
☐ Comprehensive Bleeding Disorder Panel (4825) *60 genes, 1 targeted variant (PLAU by aCGH only)*
☐ Comprehensive Platelet Disorder Panel (4830) 63 *genes (PLAU by aCGH only)*
☐ Congenital Neutropenia Panel (4845) 24 *genes*
☐ Fibrinolytic Disorder Panel (4860) *8 genes, 1 targeted variant (PLAU by aCGH) only)*
☐ Fibrinogen Disorders Panel (4885) *3 genes*
☐ Glanzmann Thrombasthenia Panel (4870) *2 genes*
☐ Hermansky-Pudlak Syndrome Panel (4875) *10 genes*
☐ Inherited Thrombocytopenia Panel (4840) *42 genes*
☐ Platelet Function Disorder Panel (4835) *41 genes, (PLAU by aCGH only*)
☐ Thrombosis Panel (4820) 12 *genes, 2 targeted variants*

☐ Custom Blood Disorder Panel (4850) *Two Gene minimum, 10 gene maximum. If greater than 10 genes desired, please call 800-245-3117 ext. 6250*
Genes: _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____

**PLAU* available via aCGH only § *SERPINA1* is targeted for the Pittsburgh allele in exon 5 only

☐ Single Gene Analysis (4855) _____ *(If more than one gene is considered, please call 800-245-3117 ext. 6250 to determine if a custom panel is a more cost-effective option.)*
**PLAU* available via aCGH only

Specific Orders - *Unless otherwise noted, Box B must be completed for each order.*

Hemophilia	**Other Testing**
☐ Factor VIII (*F8*) Genetic Analysis (4855) *Inversion analysis not included*	☐ *ADAMTS13* Genetic Analysis (4855)
☐ Factor VIII (*F8*) Severe HA Analysis Reflex (1403) *inversion, reflex to seq* **does not require Box B.* ☐ *Check here if further reflex to F8 aCGH is desired* ☐ *Check here to add concurrent F8 aCGH*	☐ *ELANE* Genetic Analysis (4855) ☐ Factor V Leiden (1035) **does not require Box B.*
Factor VIII (*F8*) Inversion Analysis **does not require Box B.* ☐ ***Both*** Introns 1 and 22 (1402) ☐ Intron 22 ***Only*** (1400) ☐ Intron 1 ***Only*** (1401)	☐ Hemoglobin SC Mutation Analysis (4624) **does not require Box B.*
☐ Factor IX (*F9*) Genetic Analysis (4855)	☐ Prothrombin Gene Mutation (1024) **does not require Box B.*
von Willebrand Disease	
☐ *VWF* Genetic Analysis (All Exons) (4855)	☐ VWD Platelet-Type Sequence Analysis (1289) (*GP1BA*) **does not require Box B.*
☐ *VWF* Exon 28 Sequence Analysis (For Type 2M or 2B VWD) (1284) **does not require Box B.*	☐ VWD Type 2N Sequence Analysis (1288) (*VWF* exons 17-21, 24-27) **does not require Box B.*

Familial Testing

☐ Targeted Familial Variant Analysis (4970) **If proband was not tested at Versiti, call to discuss if a control sample is needed** **does not require Box B.*

Gene: _____ Exon: _____ Variant: _____ Proband name: _____ Relationship to Proband: _____

§ *SERPINA1* is targeted for the Pittsburgh allele in exon 5 only

Box B: Order Detail – Complete for *each* order, unless otherwise noted

☐ NGS Sequencing **Only**
☐ Deletion/Duplication by aCGH **Only**
☐ NGS Sequencing with **Reflex** to Deletion/Duplication by aCGH
☐ NGS Sequencing with **Concurrent** Deletion/Duplication by aCGH

Versiti Use Only

____EDTA ____ACDA
____Amnio ____ CVS
____Heparin ____BM

Opened By _____
Evaluated By _____

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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.	

VERIFICATION OF INFORMED CONSENT

It is recommended that healthcare providers obtain a signed informed consent from the patient when genetic testing is ordered. By signing the informed consent, the patient agrees that that they have received and understand the indications and implications of the genetic test and are voluntarily agreeing to have the test performed. In some states, informed consent is **required** by existing laws and regulations. Versiti recommends that ordering healthcare providers verify their state laws and regulations regarding informed consent for genetic testing. An informed consent form may be available from your institution or one can be found at http://www.versiti.org/hg under *forms.* Information regarding a general description of the test, purpose, sensitivity, analytical limitations, and the features and genetics of the condition(s) is also available in the Versiti test catalog.

New York State patients: New York state healthcare providers are required to provide verification that informed consent (complying with New York State Department of Health Genetic Testing Standard 5 [GT S5] and New York State Civil Rights Law, Section 79-l) has been obtained from their patient. In order for genetic testing to be performed in our laboratory, please sign the verification below or submit a signed informed consent form. The sample will be destroyed not more than 60 days after the sample was obtained, unless a longer period of retention is expressly authorized in the consent

Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test(s) ordered above and I authorize the testing of the enclosed specimen(s). I understand that no tests other than those authorized will be performed on genetic samples.

_____ _____

Signature of healthcare provider Date

If patient is making payment, please select payment type and submit a completed Patient Billing Form:

☐ Check (Payable to Versiti Wisconsin) ☐ Credit Card

SAMPLE REQUIREMENTS

Label samples clearly with full name of individual, date, and time drawn. For sample exceptions, contact Client Services.

Source	Specimen Type	Volume Required
Parental/Patient/Pediatric	Whole Blood (lavender top)	3-5 mL
	Bone marrow (lavender top)	3-5 mL
	Buccal Swabs	3-4 swabs
	High Quality DNA	≥1µg of DNA at ≥50ng/µL
Fetal – MCC Studies recommended	Amniotic Fluid	7-15 mL
	CVS	5-10mg
	Cultured Amniocytes or CVS	Two T25 flasks ($2x10^6$ minimum)

SHIPPING REQUIREMENTS

Ship on an ice pack or at room temperature, protect from freezing. Place the specimen and the requisition into plastic bags and seal. Insert into a Styrofoam container, seal and place into a sturdy cardboard box, and tape securely. Ship the package in compliance with your overnight carrier guidelines. Label with the following address:

Versiti Wisconsin – Client Services
638 N. 18th St. Milwaukee, WI 53233-2121

Please call the laboratory (800-245-3117 ext 6250) for advice if you will ship samples near a major holiday

HEMATOLOGY GENETICS SINGLE GENES For additional information about genetic panels and more, visit: Versiti.org/HG.

ABCG5	*CDC42*	*F9*	*G6PC3*	*HOXA11*	*LAMTOR2*	*PLAU**	*SERPINA1*§	*TBXAS1*	*WAS*
ABCG8	*CSF3R*	*F10*	*GATA1*	*HPS1*	*LMAN1*	*PLG*	*SERPINC1*	*TCIRG1*	*WIPF1*
ACTB	*CXCR4*	*F11*	*GATA2*	*HPS3*	*LYST*	*PRKACG*	*SERPIND1*	*THBD*	
ACTN1	*CYCS*	*F13A1*	*GFI1*	*HPS4*	*MCFD2*	*PROC*	*SERPINE1*	*THPO*	
ADAMTS13	*DIAPH1*	*F13B*	*GFI1B*	*HPS5*	*MECOM*	*PROS1*	*SERPINF2*	*TUBB1*	
ANKRD26	*DTNBP1*	*FERMT3*	*GGCX*	*HPS6*	*MPIG6B*	*RAB27A*	*SLC37A4*	*USB1*	
ANO6	*ELANE*	*FGA*	*GNE*	*HRG*	*MPL*	*RAC2*	*SLFN14*	*VIPAS39*	
AP3B1	*ETV6*	*FGB*	*GP1BA*	*ITGA2B*	*MYH9*	*RASGRP2*	*SRC*	*VKORC1*	
AP3D1	*F2*	*FGG*	*GP1BB*	*ITGB3*	*NBEA*	*RBM8A*	*STIM1*	*VPS13B*	
ARPC1B	*F5*	*FLI1*	*GP6*	*JAGN1*	*NBEAL2*	*RNU4ATAC*	*STXBP2*	*VPS33B*	
BLOC1S3	*F7*	*FLNA*	*GP9*	*KDSR*	*P2RY12*	*RUNX1*	*TAZ*	*VPS45*	
BLOC1S6	*F8*	*FYB1(FYB)*	*HAX1*	*KNG1*	*PLA2G4A*	*SBDS*	*TBXA2R*	*VWF*	

aHUS/DDD Genetic Panel genes *C3, C4BPA, C4BPB, CFB, CFH, CFHR1, CFHR3, CFHR4, CFHR5, CFI, DGKE, LMNA, MCP* are NOT available as single gene sequencing

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