RepeatDx

REQUISITION FORM
Telomere Length Measurements

Today's date:	Store patient sample at room temperature **Do not refrigerate**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth Date: mm / dd / yyyyy	Sex ❑ M ❑ F
Patient ID#:			Sample Collection Date mm / dd / yyyyy	Time hh / mm

REASON FOR TESTING

❑ Bone Marrow Failure	❑ Immunodeficiency	❑ Lymphoid Malignancy	❑ Myeloid Malignancy
❑ Pulmonary Fibrosis	❑ Other Lung Disease	❑ Other, please specify:	

ORDERING INFORMATION

Physician:	NPI#:	
Hospital:		
Address:		
City:	State:	Zip Code:
The person listed as the Ordering Physician is authorized by law to order the test. **Authorized Signature (Required):**	Results to be sent by: ❑ Fax: __________ ❑ Email:__________	

TEST REQUESTED

Repeat Diagnostics uses the Flow FISH procedure. Turnaround time is within 3 weeks. For expedite service, please contact us.

❑ **2-Panel Assay** Telomere length measurements for total **lymphocyte** and **granulocyte** populations only. $650.00

❑ **6-Panel assay** Telomere length measurements for total **lymphocytes** and **granulocytes** as well as **B-cells**, **T-cells** and **NK cells**. $1050.00

Medical consultation is required by New York State Public Health Law and is included in the cost of the assay. Provide pertinent patient information, such as family history, clinical history, current working diagnosis, symptoms and lab investigations. If the space allocated is not enough, please provide additional information on a separate sheet:

PATIENT MEDICAL INFORMATION

BILLING OPTIONS
(We do not invoice healthcare insurance companies)

Institutional Billing:		**Patient Billing** Credit card (VISA & MasterCard)	
Hospital:		Name on Credit Card:	
Department:		Address:	
Contact:		City:	
Address:		State:	Zip Code:
City:		Card number:	
State:	Zip Code:	Exp. Date (mmyy):	CVC:
Tel:		Signature of Cardholder:	
Email:		Please charge the above credit card in the amount of $	

Repeat Diagnostics Inc. 309-267 West Esplanade North Vancouver, BC V7M 1A5 Toll Free 1-855-295-7173

Form USNY032017

Repeat DX

Toll Free: 1-855-295-7173
Phone: 604-985-2609
Fax: 778-340-1144
info@repeatdiagnostics.com
www.repeatdiagnostics.com

Informed Consent for New York Residents Requesting Telomere Length Testing

I have been counseled and understand that:

1. My health care provider wants me to have a test for median **Telomere Length** measurement.
2. Patients are required to give informed consent prior to having telomere testing which has a genetic component. Prior to consenting to telomere testing, I may find counseling by a genetic counselor or other professional helpful in weighing the benefits and drawbacks of this test.
3. The telomere length measurement offered by Repeat Diagnostics is performed to identify telomere length abnormalities that may cause or predispose to disease.
4. Telomere length tests can be offered to confirm or rule out a diagnosis, to test for a disease before symptoms develop or to determine suitability for bone marrow donation. My health care provider will tell me about why he/she would like to order telomere length testing.
5. A normal telomere length test result for a disease will not completely rule out that disease. My health care provider will use my health and family history to interpret what the normal result means for me.
6. An abnormal telomere length result may mean that I have or am predisposed to developing a disease. There may be additional testing to evaluate or clarify my medical status. I may consult my health care provider or ask to be referred to a genetics professional to discuss the implications of my test results and any additional testing that would be helpful.
7. Results will only be released to authorized personnel.
8. Links to how the test will be performed are available from the Repeat Diagnostics web site at www.repeatdiagnostics.com

______________________________ ______________________________

Patient Signature Date

____

Name

____

Physician Signature

BEFORE COLLECTION OF BLOOD

Sample should **only** be collected and shipped on Monday, Tuesday or Wednesday.

Requisition Form check list

- ❑ Patient name is filled in and matches blood tube ID (first identifier)
- ❑ Second patient identifier (date of birth, unique ID number) is filled in and matches blood tube
- ❑ Ordering information is complete and signed by the requesting physician
- ❑ Result send out information is completed
- ❑ Assay type (2 or 6-panel) and optional consultation are selected accordingly
- ❑ Payment information is completed

SPECIMEN COLLECTION

Label the specimen tube with:
 Patient Name and ID #
 Age
 Sex
Date and time of collection
Collect blood in EDTA anti-coagulant tube.
5-10ml of blood is required for successful testing.
Store patient sample at **room temperature** until pick-up by courier.
All blood shipments to Repeat Diagnostics must arrive within 2 days and in good condition.

SPECIMEN PACKING AND SHIPPING

SHIPPING MATERIAL

UN3373 shipping box measuring approximately 9” X 4” X 4”, labeled “Biological Substance Category B)
Specimen bag or sealable plastic bag.
Absorbent material such as paper towel.
Packing tape.
Address label.
FedEx Clinical Pak (provided free of charge from FedEx)
International Air Waybill.
Commercial Invoice.
For more information on how to ship clinical samples visit FedEx at
 http://images.fedex.com/downloads/shared/packagingtips/pointers.pdf

SHIPPING

1. Place blood collection tube(s) in sealable plastic bag.
2. Place bag in shipping container. ICE PACKS ARE NOT REQUIRED
3. Place enough absorbent material in shipping container so that blood tubes do not roll around.
4. Seal shipping container with packing tape.
5. Attach address label to top of shipping container.
6. Place shipping container and requisition form inside FedEx Clinical Pak.
7. Fill out the international Air Waybill form.
8. Fill out commercial invoice form. Minimal dollar value must be $4.00 to ensure rapid customs processing.
9. Include 5 copies of the Commercial Invoice with the waybill.
10. Ship on day of collection by **FedEx International Priority** to:

 Repeat Diagnostics Inc.
 Suite 309 - 267 West Esplanade
 North Vancouver, BC V7M 1A5
 Canada

11. Inform Repeat Diagnostics by email at test@repeatdx.com of date shipped and tracking number.

COMMERCIAL INVOICE

Date of Exportation:	Export References : Clinical Diagnostic Test
Shipper/Exporter (complete name and address)	Consignee: Repeat Diagnostics Suite 309 267 West Esplanade North Vancouver, BC V7M 1A5 Canada T. 604-985-2609 F. 778-340-1144
Country of Export United States	Importer same as consignee: Repeat Diagnostics Customs Broker is : **FedEx EXPRESSCLEAR** Vancouver BC Canada
Country of Origin of Goods United States	
Country of Ultimate Destination Canada	

International Air Waybill No.

Marks/Nos.	No. of Pkgs.	Type of Packaging	Full Description of Goods	Qty.	Unit of Measure	Weight	Unit Value	Total Value
	1	Box	Fresh Cells Human White Blood Cells	1		0.5 kilo	4.00	4.00
			For Diagnostics Testing					0.00
			Non-infectious/Non-hazardous/Non-toxic/Non-volatile					0.00
			No Commercial Value					0.00
								0.00
								0.00
TOTAL	1					0.5 Kgs		$4.00

Return to: ______________________

These commodities are licensed for the Ultimate Destination shown.
Diversion contrary to United States law is prohibited.

Check One
- [x] F.O.B.
- [ ] C&F
- [ ] C.I.F.

I declare all the information contained in this invoice to be true and correct.

Signature of Shipper

(Type name and title)

Date

LAB.003.F02.00