

REQUISITION FORM TELOMERE LENGTH MEASUREMENT

For New York State Residents Only

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

Toll Free 1-855-295-7173 Fax 778-340-1144

Ordering Physician Last Name:	Patient Information Last Name:						
First Name:	First Name:						
Hospital:	Patient Sample ID#:						
Department:	DOB (mm/dd/yyyy) Gender:						
Address:	Specimen Collection Collect at least 5 ml of blood in a						
	standard EDTA, or 10 ml or more if WBC is low or unknown.						
City:							
Chaha.	Collection Date: (mm/dd/yyyy)						
State: Zip Code:	Collection Time: (hh:mm)						
Authorized Signature: (required)	Lab Contact Person:						
Payment Option Repeat Diagnostics does	not bill healthcare insurance companies						
Bill hospital: Address below Credit Card Bill	patient: Check Provide address below for receipt						
Email:	Credit Card (VISA or Mastercard)						
Address:	Credit card number:						
	Exp Date: (mm/yy) 3 digit code						
City:	No see an avadit acad.						
State ZipCode:	Name on credit card:						
Tel:	Signature of Card Holder (required)						
Email:	For services performed by Repeat Diagnostics, please charge the above credit card in the amount of \$						
TEST INFORMATION Turnaround time: within 3 we	eks. For expedited service, please contact us.						
2-Panel Assay - measurements on total lymphocyte and granulocyte population \$650.00							
6-Panel Assay - 2-Panel Assay PLUS measurements f	or 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:							
RESULTS can be emailed, faxed or both. Your preference	e:						
Fax number(s): Email addres	ss(es):						
PDI #:	Form NY102014						



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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		

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



TELOMERE LENGTH MEASUREMENT

SPECIMEN COLLECTION AND SHIPPING PROCEDURE

BEFORE COLLECTION OF BLOOD

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

Requisition Form check list

- □ requisition is signed by the requesting physician
- □ 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
- ☐ result send out contact information is completed
- □ payment information is completed
- □ assay type (2 or 6-panel) and optional consultation are selected accordingly

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.
- All blood shipments to Repeat Diagnostics must arrive within 2 days and in good condition.

SPECIMEN PACKING AND SHIPPING

SHIPPING MATERIAL

- Shipping container (UN3373 box 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:



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 Inform Repeat Diagnostics by email at <u>test@repeatdiagnostics.com</u> of date shipped and tracking number.



COMMERCIAL INVOICE								
Date of shipment to Canada		Export References (order no., invoice no., etc.)						
Shipper/Exporter (complete name and address)		Consign	nee (con	nplete name	and addres	s)		
		Repeat Diagnostics Inc Suite 309 – 267 West Esplanade Avenue North Vancouver, BC V7M 1A5 Canada						
		Toll Free 1-855-295-7173 T. 604-985-2609 F. 778-340-1144						
Country of Export United States		Importer -	Importer - If other than Consignee					
Country of Origin of Goods	Country of Origin of Goods		Repeat Diagnostics Customs Broker is:					
Unite	d States		FedEx 1	EXPRESSCI	LEAR			
Country of Ultimate Destination								
Canada								
Shipment is FOB North Vancouver	International Air W	aybill No.						
No. of Pkgs Type of Packaging Full E	Full Discription of Goods		Qty.	Weight	Unit Value	Total Value		
Spec Non- Non-	Fresh Human Whole Blood Specimen for Diagnostic Testing Non-infectious, non-hazardous, Non-toxic, non-volatile		1	0.3 Kilo	4.00	4.00		
No c	commercial value							
1				0.3 Kgs		4.00		
These commodities are licensed for the	he Ultimate Destination show	n.						
I declare all the information contained in this invoice to be true and correct.								
Signature of Shipper:			Date:					
Print name and title:								