Phone: (412) 209-7270 (option 2)
Fax: (412) 209-7457
Email: VCLGeneticTesting@vitalant.org
Website: vitalanthealth.org/clinical-services/laboratory/coagulation

VITALANT COAGULATION LABORATORY GENETICS TEST REQUISITION

PATIENT INFORMATION

Last Name: | **First Name:** | **MI:**

Date of Birth: | **MRN:**

Biologic Sex / Sex Assigned at Birth:
- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Unknown

Karyotype: _____

Patient Reported Ancestry (check all that apply):
- ☐ Amish
- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Middle Eastern
- ☐ Native American
- ☐ White/Caucasian
- ☐ Other:_____

ORDERING PROVIDER / INSTITUTION

Individual completing test requisition:

Institution/Organization Name or Account Number:

Street Address:

City: | **State:** | **Zip Code:**

Provider Name:

Phone Number: | **Email:** | **Fax:**

NPI: | **Send additional reports to:**

SPECIMEN INFORMATION

Specimen type: ☐ EDTA blood (3-5ml) ☐ DNA Draw Date: Draw Time:

PATIENT HISTORY

Does this patient have a history of:

Allogeneic bone marrow transplant? ☐Yes ☐No Hematologic malignancy? ☐Yes ☐No Blood transfusion within 3 months of draw? ☐Yes ☐No

Please consult the laboratory before sending a sample if the answer is yes to any of the above questions.

Clinical Diagnosis: | **Clinical Presentation:** | **Laboratory Findings:**

Family history of clinical diagnosis listed above (provide details and/or include pedigree):

Relative/Sex	Maternal/Paternal	Disease Status*	Relative/Sex	Maternal/Paternal	Disease Status*
	☐ M ☐ P			☐ M ☐ P	
	☐ M ☐ P			☐ M ☐ P	
	☐ M ☐ P			☐ M ☐ P	

*Disease status should be listed as affected, unaffected, unsure, known carrier, not evaluated.

STATEMENT OF MEDICAL NECESSITY

By signing this form, I affirm each of the following:

1. I authorize Vitalant Coagulation Laboratory to complete the testing indicated.
2. The test being ordered is clinically appropriate, medically necessary, and the results can inform medical management.
3. Informed consent has been obtained from the patient or legal guardian in accordance with provider state laws and regulations.

Physician or Authorized Provider (Signature/Date): _____

Test Requested:

Test Name	Test Code
☐ FVIII (F8) Intron 1 & Intron 22 Inversion Analysis	6422
☐ FVIII (F8) Intron 22 Inversion Analysis	6424
☐ FVIII (F8) Intron 1 Inversion Analysis	6425
☐ Factor IX (F9) p.Thr342Met Gene Variant	6413

Ship specimens cooled or at room temperature. Do not freeze. Whole blood specimens should be received within 3 days of draw.

Ship specimens to: Vitalant Coagulation Laboratory, 875 Greentree Road, 5 Parkway Center Suite 122, Pittsburgh, PA 15220