LabPMM®
an invivoscribe® company

Test Requisition Form

10222 Barnes Canyon Road, Building 1
San Diego, CA 92121
Phone: 858.224.6650
Fax: 858.224.6655
www.invivoscribe.com/clinical-services
CLIA# 0501078819 / CAP# 7199699

Received Date:	
Time:	Tech:
Specimen Volume:	
Tube/Container:	
Accession #:	

Patient Label

PATIENT INFORMATION

*REQUIRED INFORMATION

Name*:

Date of Birth*:

Reported Ancestry:

Medical Record #: | Gender: ☐ M ☐ F

SPECIMEN TYPE:

Bone Marrow

☐ 2-4 mL in EDTA or Sodium Heparin for Hematolymphoid Screening Panel

☐ 3-5 mL in EDTA or Sodium Heparin for AML MRD Assay

Peripheral Blood

☐ 2-4 mL in EDTA or Sodium Heparin for Hematolymphoid Screening Panel

Transport specimens ambient (18-25°C/64-77°F) or with cold packs in provided packaging. If using cold packs for transport, make sure cold pack is not in direct contact with specimen. Do not freeze. Specimens should arrive in the laboratory within 48 hours of collection.

PHYSICIAN/CLIENT INFORMATION

*REQUIRED INFORMATION

Physician*:

Institution*:

Address*: | Medicare #:

Address 2:

Phone*: | Fax:

Email:

MULTIPARAMETER FLOW CYTOMETRY TEST REQUESTED

☐ **Hematolymphoid Screening Panel (29 biomarkers)**

CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11b, CD13, CD14, CD15, CD16, CD19, CD20, CD23, CD33, CD34, CD38, CD45, CD56, CD57, CD64, CD71, CD117, CD123, HLA-DR, Kappa, Lambda, and TCR Gamma/Delta.

☐ **AML MRD Assay (21 biomarkers)**

CD2, CD4, CD5, CD7, CD11b, CD13, CD14, CD15, CD16, CD19, CD33, CD34, CD36, CD38, CD45, CD56, CD64, CD117, CD123, HLADR, 7AAD.

* Bone Marrow in EDTA or Sodium Heparin is the only specimen type accepted.

SAMPLE INFORMATION

WBC count:	%Blasts:	Diagnosis:
Tumor %:	Tissue Source:	ICD10 Code:
Date of Collection:	Time:	Reason for Submission:

Has the patient received an ***Allogenic Stem Cell Transplantation***: ☐ Yes ☐ No

Please send all pathology and test results from molecular assays, flow cytometry and any other ancillary clinical information.

RESEARCH

LabPMM® may use your leftover specimen and your health information, including genetic information, in an anonymized, or de-identified, form (unless otherwise allowed by applicable law) for research and education purposes. Such uses may result in the development of commercial products and services. You will not receive notice of any specific uses and you will not receive any compensation for these uses. All such uses will be in compliance with applicable law. You may refuse to allow LabPMM® to use your leftover specimen or information for research by marking the applicable box below. You may also withdraw your consent for research uses at a later date by submitting an "Opt-Out of Research Form" to the laboratory.

☐ Opt Out of Research Patient Signature:

LabPMM® PATIENT INFORMED CONSENT

I, the patient, certify to having the assay performed, acknowledge that:

I understand that this test is voluntary and I have had the opportunity to ask questions and discuss with my healthcare provider the risks, benefits and alternatives of this test. I have been informed about the availability of genetic counseling and have been provided with information identifying an appropriate healthcare provider from whom I might obtain such counseling. I have read and understand the content of this document and may have a copy if desired. These test results may impact life, disability, and long-term care insurance. I understand that my sample will be tested for many different genes that may have conditions that impact me and my blood relatives. The American College of Medical Genetics and Genomics (ACMG) suggests that secondary findings be discussed with those who share these variants with me. I have considered the way to communicate this information to them.

Patient Signature: _____