Repeat Dx

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 / yyyy	Sex ☐ M ☐ F
Patient ID#:	Sample Collection Date mm / dd / yyyy	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 l**ymphocyte** and **granulocyte** population only.

☐ **6-Panel assay** Telomere length measurements for total l**ymphocytes** and **granulocytes** as well as **B-cells**, **T-cells** and **NK cells**.

☐ **Medical Consultation** $250.00 for a written evaluation by a hematopathologist to accompany the test results. 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 $	

TELOMERE LENGTH MEASUREMENTS
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

- ☐ 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

- ☒ 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