



# REQUISITION FORM

## TELOMERE LENGTH MEASUREMENT

Repeat Diagnostics Inc  
 309 - 267 West Esplanade Ave.  
 North Vancouver, BC V7M 1A5, Canada  
 Toll Free 1-855-295-7173  
 F. 778-340-1144

<p><b>Ordering Physician</b></p> <p>Last Name:</p> <p>First Name:</p> <p>Hospital:</p> <p>Dept:</p> <p>Address:</p> <p>City:</p> <p>Country:</p> <p><b>Authorized Signature:</b> (required)</p> <p>_____</p>	<p><b>Patient Information</b></p> <p>Last Name:</p> <p>First Name:</p> <p>Patient Sample ID#:</p> <p>DOB (mm/dd/yyyy) <span style="float: right;">Gender:</span></p> <hr/> <p><b>Specimen Collection</b> Collect <b>at least 5 ml</b> of blood in a standard EDTA, or 10 ml or more if WBC is low or unknown.</p> <p>Collection Date : (mm/dd/yyyy)</p> <p>Collection Time: (hh:mm)</p> <p>Lab Contact Person:</p>
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**Payment Option** Repeat Diagnostics does not bill healthcare insurance companies

Bill hospital: <input type="checkbox"/>	Address below <input type="checkbox"/>	Credit Card <input type="checkbox"/>	Bill patient: <input type="checkbox"/>	Check <input type="checkbox"/>	Provide address and Tel # below for receipt <input type="checkbox"/>
	Email <input type="checkbox"/>			Credit Card (Visa or Mastercard in US funds) <input type="checkbox"/>	

<p>Address:</p> <p>City:</p> <p>Region: <span style="float: right;">P Code</span></p> <p>Tel:</p> <p>Email:</p>	<p>Credit card number:</p> <p>Exp. date: <span style="float: right;">3 digit code</span></p> <p>Name on credit card:</p> <p>Signature of cardholder (required): _____</p> <p>For services performed by Repeat Diagnostics, please charge the above credit card in the amount of \$</p>
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**TEST INFORMATION** Turnaround time: within 3 weeks. For expedited service, please contact us.

2-Panel Assay - measurements on total lymphocyte and granulocyte population

6-Panel Assay - 2-Panel Assay PLUS measurements for 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:

**RESULTS:** Results can be emailed, faxed or both. Your preference:

Fax number(s): \_\_\_\_\_ Email address(es): \_\_\_\_\_

### 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:



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

11. Inform Repeat Diagnostics by email at [test@repeatdiagnostics.com](mailto:test@repeatdiagnostics.com) 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)	Consignee (complete name and address)  Repeat Diagnostics Inc Suite 309 – 267 West Esplanade Avenue North Vancouver, BC V7M 1A5 Canada  T. 604-985-2609 F. 778-340-1144
Country of Export	Importer - If other than Consignee  Repeat Diagnostics Customs Broker is:  <p style="text-align: center;"><b>FedEx EXPRESSCLEAR</b></p>
Country of Origin of Goods	
Country of Ultimate Destination  <p style="text-align: center;"><b>Canada</b></p>	

<b>Shipment is FOB North Vancouver</b>	<b>International Air Waybill No.</b>
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No. of Pkgs	Type of Packaging	Full Discription of Goods	Qty.	Weight	Unit Value	Total Value
<b>1</b>	<b>Box</b>	<b>Fresh Human Whole Blood Specimen for Diagnostic Testing</b>  <b>Non-infectious, non-hazardous, Non-toxic, non-volatile</b>  <b>No commercial value</b>	<b>1</b>	<b>0.3 Kilo</b>	<b>4.00</b>	<b>4.00</b>
<b>1</b>				<b>0.3 Kgs</b>		<b>4.00</b>

These commodities are licensed for the Ultimate Destination shown.

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

Signature of Shipper: \_\_\_\_\_ Date: \_\_\_\_\_

Print name and title: \_\_\_\_\_

Include 5 copies with the international waybill