DNA REPAIR CLINICAL TESTING REQUISITION

11600 Wilshire Blvd, Suite 410
Los Angeles, CA 90025
Phone:(424) 387-8100 Fax: (424) 387-8101

FOR LABORATORY USE ONLY

PATIENT NAME:
(LAST) (FIRST)

MEDICAL RECORD NUMBER:

DATE OF BIRTH:
SEX: M F

ATTACH DEMOGRAPHIC LABEL OR FILL IN ALL ABOVE INFORMATION

INSTITUTION NAME _____ ORDERING PHYSICIAN _____

PHYSICIAN ID NUMBER

ORDERING PHYSICIAN SIGNATURE _____ DATE _____ TIME _____

M M D D Y Y
COLLECTION DATE

ADDRESS:_____

SPECIMEN DRAW

PHONE:_____ FAX:_____ UPIN: _____

TIME:_____

SPECIMEN COLLECTED

COPY TO: PHYSICIAN: _____

BY:_____

ADDRESS:_____

PHONE:_____ FAX:_____

SPECIMEN TYPE	PATIENT INFORMATION/HISTORY	GENETIC
Please Ship at Room Temperature ☐ One 7ml green-top (sodium heparin), whole blood (required for EBV transformation and western) ☐ Fibroblast Culture ☐ One 8 ml purple top for DNA isolation (for sequencing)	Pertinent Family History:_____ Ethnicity:_____ ☐ Consanguinity: ☐ Yes ☐ No ☐ Familial Mutation(s) Known:_____ **Primary Counseling Issue for Genetic Disease** ☐ Proband Diagnosis:_____ ☐ Prenatal Diagnosis:_____ ☐ Carrier Screen:_____ ☐ Presymptomatic Diagnosis:_____ ☐ Other:_____	☐ Prenatal Family History Previous Diagnosis

SEQUENCING	IMMUNOBLOTTING	SPECIAL INSTRUCTION
☐ Full-ATM Sequencing ☐ Targeted-ATM Sequencing ☐ EryDel Project only	☐ ATM protein	☐ **MISCELLANEOUS** ☐ EBV-transformation

MIraDx
DNA Repair Clinical Testing Laboratory
Richard Gatti, M.D.,Director
Joanne Weidhaas, M.D., Ph.D., Founder
Phone: (310) 529-9040; (310) 650-3431
Version 5: 2/16/2017

miraDX

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Instructions for Referred Testing

Specimen: Follow specimen instructions on the requisition form.
Label all specimens with Patient name, I.D. numbers, date and time of collection.

Information: Fill out Client information, Patient information, and Specimen information areas. Submit a separate form for each patient (copies are acceptable). Select test being requested.

Mail:
Please ship **OVERNIGHT EXPRESS AT ROOM TEMPERATURE.**
Send specimens with completed forms (**Monday--Thursday)** to:

MiraDx, DNA REPAIR CLINICAL LABORATORY REQUISITION
11600 Wilshire Blvd
Suite 410
Los Angeles, CA 90025

Contact email: jreiss@miradx.com
Phone: (424) 387-8100 Fax: (424) 387-8101

Billing Information

Responsible Contact Name: _____

Institution:_____

Address: _____
City State Zip

Alternate Contact Person: _____

Phone: _____ **FAX:** _____