Blood Disease Mutation Analysis Requisition

*ALL SECTIONS OF REQUISITION MUST BE FILLED IN PRIOR TO SUBMITTING SAMPLES.

ADDRESS SAMPLES TO:
Attention: Teresa Silva
Blood Disease Reference Laboratory
Department of Pathology, CB-541a
310 Cedar Street, New Haven, CT 06520
Tel. 203-737-1349 Fax 203-785-3896

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. NO.
CITY	STATE	ZIP
PHONE NUMBER	SSN	
DATE OF BIRTH - MM/DD/YYYY	AGE / SEX	PATHOLOGY #

RACE/ETHNICITY (Check ALL that apply)

- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ WHITE
- ☐ HISPANIC OR LATINO
- ☐ NON-HISPANIC OR LATINO

PARENTAL CONSANGUINITY: ☐ **YES** ☐ **NO**

REFERRING PHYSICIAN

PHYSICIAN NAME		
STREET ADDRESS		
CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER	
EMAIL		
GENETIC COUNSELOR/LABORATORY NAME		
PHONE NUMBER	FAX NUMBER	
EMAIL		
REFERRING PHYSICIAN/COUNSELOR SIGNATURE (required):	DATE	

FAX RESULT TO: _____

CLINICAL HISTORY and PROVISIONAL DIAGNOSIS

SPECIMEN INFORMATION

SPECIMEN TYPE: ☐ **Blood** **
☐ **Tissue** (specify): _____
☐ **Other** (specify): _____

SPECIMEN DRAW DATE: ___/___/___ **TIME:** _____

SPECIMEN AMOUNT: _____

DRAWN BY:

_____

** Specimen Preparation: Whole blood samples of at least 5 ml in EDTA (Purple Tube) should be submitted at room temperature.

TEST REQUESTED

Hereditary Spherocytosis
- ☐ Alpha spectrin
- ☐ Beta spectrin
- ☐ Ankyrin
- ☐ SLC4A1 (Band3 Protein)

Hereditary Pyropoikilocytosis
- ☐ Alpha spectrin
- ☐ Beta spectrin

Hereditary Elliptocytosis
- ☐ Alpha spectrin
- ☐ Beta spectrin

Hereditary Stomatocytosis
- ☐ SLC4A1 (Band3 Protein)

Southeast Asian Ovalocytosis (SAO)
- ☐ SLC4A1 (Band3 Protein)

Congenital Dyserythropoietic Anemia
- ☐ CDAN1
- ☐ SEC 23B
- ☐ KLF1

Pyruvate Kinase Deficiency
- ☐ PKLR

Hemoglobin Disorders
- ☐ HBA1
- ☐ HBA2
- ☐ HBB

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For Billing Information, contact:	Pathology Department Billing Office, LH11, PO Box 208023, New Haven, CT 06520-2083 Tel 203-737-1857, Fax 203-737-4690
For Medical Issues, please contact:	Pei Hui, M.D., Laboratory Director, Tel 203-785-6498 or email: pei.hui@yale.edu

Appropriate billing mechanism should be established before the specimen is admitted for testing (use the form on next page). A consent form signed by the patient or the guardian should be obtained and filed by the submitting physician. Medical Necessity Regulations: At the government's request, the Yale Blood Cell Disease Reference Laboratory would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

Website: www.yaleblooddiseaselab.org

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Blood Disease Reference Laboratory
PATIENT BILLING INFORMATION

Please select only ONE method of payment:

☐ INSURANCE / POLICY HOLDER INFORMATION

Name _____ **Insurance Name** _____

Date of Birth _____ ☐ **Male** ☐ **Female** **Insurance Address** _____

Authorization Number _____ _____

Insurance ID Number _____ **City** _____

Group Number _____ **State** _____ **Zip Code** _____

☐ REFERRING INSTITUTION

Institution _____ **Contact Name** _____

Address _____ **Phone** _____

Address #2 _____ **Fax** _____

City _____ **Email** _____

State _____ **Zip Code** _____

☐ BILL PATIENT DIRECTLY

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