MACHAON DIAGNOSTICS

New York-specific Test Requisition Form

MachaonDiagnostics.com
Toll-free: (800) 566-3462

Northern California Lab (PFI: 9439)
Medical Director: Brad Lewis, MD
2023 Eighth Street, Berkeley, CA 94710
Phone: (510) 839-5600 / Fax: (510) 839-6153

New Orleans Lab (**local samples can be sent directly)
Medical Director: Gloria Coker, MD
8721 Oak Street, New Orleans, LA 70118
Phone: (504) 866-7090 / Fax: (504) 866-7091

PATIENT HISTORY

Patient's Name: (Last, First, M.I.)* | Specimen Date and Time:*

Sex:* M F | DOB:* | MRN:* | Ordering Provider: (Last, First)*

Platelet Count_____ (K/µL), aPTT_____ (sec.), PT_____ (sec.), INR_____
Hematocrit_____ (%), Bleeding History_____ (Y/N), Clotting History_____ (Y/N)

☐ Patient is anticoagulated
☐ Patient is on antiplatelet medication
☐ Patient is on Hemlibra therapy

Please specify:
☐ coumadin ☐ LMWH ☐ UFH ☐ apixaban ☐ rivaroxaban
☐ dabigatran ☐ fondaparinux ☐ other _____
☐ Aspirin ☐ Plavix ☐ Brilinta ☐ other _____

SUBMITTING FACILITY

Client Account #:
Facility Name and Address:*

*= REQUIRED

Phone:* Fax for results:*

☐ STAT ☐ ASAP ☐ INSURANCE BILL ICD-10(s)_____

New York Approved Tests (visit our website for full list of approved tests and updates)

☐ aHUS Genetic Panel (20 genes); (STAT <48 Hours, M-F)
☐ TMA-Complete™ Genetic Panel (20 genes); (STAT <48 Hours, M-F)
☐ ADAMTS13 Activity (reflexes to ADAMTS13 Inhibitor); (STAT <24 Hours)
☐ ADAMTS13 Gene Sequencing (STAT <48 Hours, M-F)
☐ ACL (Anticardiolipin - IgG, IgM and IgA)
☐ Beta-2 Glycoprotein I Antibody (IgG, IgM and IgA)
☐ Factor Activity (aPTT-based) ☐ test all factors
☐ VIII (8) ☐ IX (9) ☐ XI (11) ☐ XII (12)
☐ Factor Activity (PT-based) ☐ test all factors
☐ II (2) ☐ V (5) ☐ VII (7) ☐ X (10)
☐ Inhibitor to Factor(s) (Bethesda Units)
☐ VIII (8) ☐ IX (9) ☐ XI (11) ☐ XII (12)
☐ II (2) ☐ V (5) ☐ VII (7) ☐ X (10)
☐ Anti-CFH Autoantibody
☐ HLH Genetic Panel 3.0 (36 genes); (STAT <48 Hours, M-F)
☐ ADAMTS13 Antibody (STAT <24 Hours)
☐ Antithrombin III Activity
☐ aPTT-LA (Lupus Sensitive Reagent)
☐ CXCL9 Level (STAT <24 Hours)
☐ dRVVT (dilute Russell Viper Venom Time)
☐ Fibrinogen Activity
☐ Heparin Antibody ELISA (PF4) (STAT <24 Hrs)
☐ Lupus Anticoagulant Screen (aPTT-LA, dRVVT, ACL)
☐ Mixing Study (aPTT) - reflex to incubated mix
☐ Protein C Activity
☐ Protein S Activity
☐ Soluble IL-2 Receptor Alpha (STAT <24 Hours)
☐ Thrombin Time - TCT (confirmed w/PS)
☐ VWF Activity (Ristocetin cofactor)
☐ VWF Antigen
☐ Von Willebrand Factor Profile (STAT <24 Hours)
(Factor VIII Activity,VWF:Antigen, VWF:RCo and aPTT)

Tests Needing a New York Restricted Laboratory Permit Prior to Testing (visit our website for permit form and updates)

☐ Modified Ham 2.0 (mHam 2.0) and sC5b-9
☐ C3 Glomerulopathy Genetic Panel (6 genes); (STAT <48 Hours, M-F)
☐ Dysfibrinogenemia Genetic Panel (FGA, FGB, FGG)
☐ Soluble Complement 5b-9 (sC5b-9); (STAT <24 Hours)
☐ Hemophilia-Complete™ Genetic Panel (F8, F9, VWF, inversions)
☐ PlateletGenex™ Functional Defect Panel (31 genes)
☐ PlateletGenex™ Thrombocytopenia Panel (26 genes)
☐ Polycystic Kidney Disease (PKD) Genetic Panel (2 genes)
☐ Plasminogen Gene Sequencing
☐ CoagGenex Clotting Genetic Panel (29 genes)
☐ VWD-Complete™ Genetic Panel (VWF and GP1BA)

Informed Consent for Genetic Testing – REQUIRED for NY Samples
Providers are required to obtain informed consent from patients for genetic testing for all samples originating in New York. An informed consent form may be found at http://www.machaondiagnostics.com, along with a general description of the test, purpose, and limitations.

In lieu of submitting a copy of the signed informed consent, New York state healthcare providers may sign the below statement attesting that informed consent has been obtained from their patient. Genetic testing samples originating in NY will be destroyed not more than 60 days after collection. No tests other than those authorized will be performed on these samples.

Verification of Informed Consent:
I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test ordered on this requisition and I authorize testing of the provided specimen.

Signature of Provider:_____ **Date:**_____

Note: testing may be delayed if a consent form is not received, and no provider signature is present above.

ADDITIONAL INFORMATION

Patients with insurance coverage other than Medicare are considered out-of-network and will be billed for services not covered by their insurance provider. Medicare patients must sign an ABN, either located on the reverse side of this form or downloaded from the Machaon Diagnostics website. Patient insurance billing services are provided in accordance with the Machaon Insurance Billing Policy. Samples originating from NY-state for genetic testing are required to have a signed genetic consent document on file prior to testing.

MACHAON USE ONLY

Specimen type received:_____ Aliquots:_____
Specimen type received:_____ Aliquots:_____
Tech initials:_____ Specimen received stamp: _____
Temperature indicator acceptable (circle one): Yes / No / N/A