

### Sample shipping address:

Washington University - Department of Pathology & Immunology  
Clinical Support Services Office  
425 South Euclid Avenue, Campus Box 8024, St. Louis, MO 63110  
Tel: (314) 747-7337 | Fax: (314) 747-7336  
Email: [gps@wustl.edu](mailto:gps@wustl.edu)

### Sample drop-off locations:

Children's Hospital  
One Children's Place  
Central Receiving 2N-25  
St. Louis, MO 63110  
Tel: (314) 454-4161

North Campus Lab  
B101 CAM Building  
4940 Parkview Place  
St. Louis, MO 63110  
Tel: (314) 454-7510



**This requisition has two pages, please complete both pages to ensure testing**

PHYSICIAN ORDERING TEST (Required - NPI)				PATIENT IDENTIFICATION			
Name:				Patient Status	Inpatient	Outpatient	Office visit
Institution:				Name Last:		First	MI:
NPI:		Email:		DOB (mm/dd/yyyy):		Gender:	Male Female
Address:				Medical Record # (if applicable):			
City:		State:	Zip:	Address:			
Phone:		Fax:		City:		State:	Zip:
Alternative Contact Name:				Ethnicity (select all that apply)			
Phone:		Email:		African American	Asian	Caucasian/NW European	
NOTES:				E Indian	Hispanic	Jewish-Ashkenazi	Jewish-Sephardic
				Mediterranean	Native Hawaiian/Pacific Islander		Other:
SPECIMEN TYPE							
Date Collected (mm/dd/yyyy):			Time:	Directions 1. Draw 8 mL of peripheral blood in lavender top EDTA tube 2. Label tube with patient first/last name, DOB, and collection date/time 3. Place tube in a biohazard bag and form into document sleeve of the biohazard bag, ensuring no patient information is visible 4. Ship specimen overnight in appropriate packaging at room temperature or with cold pack (Monday-Thursday only)			
Collected By:							
Sample Type (Select one)							
Peripheral Blood							
Other:							
REASON FOR TESTING							
Required - failure to include diagnosis may delay testing							
Diagnosis:							
ICD10 Code(s):							
PATIENT REGISTRY							
Is the patient enrolled in The Severe Chronic Neutropenia International Registry (SCNIR)?						yes	no
If no, would you like to be contacted by the SCNIR for more information?						yes	no
TESTING REQUESTED							
Test includes next-generation sequencing of all coding exons of listed genes to detect single nucleotide variants and small insertions and deletions. For some cases with negative results or isolated heterozygous mutations, additional testing by alternate methodology will be performed to determine the presence of rare variant types not detected by this assay.							
<b>Severe Congenital Neutropenia Gene Set</b> (AP3B1, CSF3R, CXCR2, CXCR4, ELANE, G6PC3, GATA2, GF11, HAX1, JAGN1, KRAS, LAMTOR2, LYST, NRAS, RAB27A, RUNX1, SBDS, SLC37A4, TAZ, TCIRG1, USB1, VPS13B, VPS45, WAS)							
<b>Targeted testing for known familial mutation</b>				Gene:		Mutation:	
GPS Accession Number: G -				(or include copy of report if performed by outside lab)		Relationship to patient above:	
ADDITIONAL NOTES							
<b>Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification</b>							
I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.							
The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.							
Signature:				Date:			
<i>Below, office use only:</i>							
Date/Time Received:		Accession Number:			Technician Initial:		



### Instructions for Completing the Fillable PDF

- Use 'Tab' to move between the fields.
- Complete ALL fields to avoid any delay in processing the requisition.
- Enter phone and fax numbers beginning with area code. Do not enter any characters such as – or /. Upon entering the 10-digit number the form will automatically format. (i.e. 3147477337 will format to (314) 747-7337).
- Enter dates as mm/dd/yyyy. (i.e. 01/05/2001).
- Ordering physician NPI is required.
- Reason for Testing/Diagnosis and ICD10 codes are required in order for us to obtain pre-authorization.

### Instructions for Sending the Completed Requisition

- Completed requisitions can be faxed to (314) 747-7336 or mailed with the specimen.
- Alternatively, completed requisitions can be emailed to [gps@wustl.edu](mailto:gps@wustl.edu). For HIPAA compliance, the form either has to be 1) saved as a JPEG or 2) encrypted with a password.

#### To save form as a JPEG on a PC:

- Have the completed form open with Adobe Reader.
- Select File > Save As > Save as type > JPEG. This way the form cannot be edited.
- Attach the completed requisition to email and send to [gps@wustl.edu](mailto:gps@wustl.edu).

#### To save form as a JPEG on a Mac:

- Have the completed form open with Preview.
- Select File > Export. Select JPEG and save. This way the form cannot be edited.
- Attach the completed requisition to email and send to [gps@wustl.edu](mailto:gps@wustl.edu).

#### To encrypt form on a PC:

- Have the completed form open with Adobe Reader.
- Select Secure > Encrypt with Password.
- Compatibility should be Acrobat 7.0 and later
- Select 'Require a password to open the document'.
- Enter password and Confirm password.
- Save and close.
- Attach the completed requisition to email and send to [gps@wustl.edu](mailto:gps@wustl.edu).
- Send additional email with the password.

#### To encrypt form on a Mac:

- Have the completed form open with Preview.
- Select File > Export. Check Encrypt, enter and verify password.
- Save and close.
- Attach the completed requisition to email and send to [gps@wustl.edu](mailto:gps@wustl.edu).
- Send additional email with the password.

### Protected Health Information Transmittal Verification

- To comply with HIPAA regulations, we need to verify that any transmission of PHI data (i.e. clinical report) is being sent securely.
- The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number listed on the requisition.
- Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.
- **In the event of an erroneous transmission, Client is obligated to immediately notify the sender and to destroy the results.**
- Client may revoke this authorization or change the facsimile number by giving the Washington University School of Medicine Department of Pathology and Immunology either through written or verbal notice with at least 24 hours prior notice.

**PLEASE CALL US AT (314) 747-7337 IF YOU HAVE ANY QUESTIONS**