REQUEST FOR TESTING
Genomics Testing Laboratory
(for Red Cell testing)

Puget Sound Blood Center

is now

Bloodworks Northwest

921 Terry Ave, Seattle, WA 98104

Upon completion print and send, along with sample, to Genomics Testing Laboratory

Time Received

See the back of this order form for sample requirements. Current test descriptions and CPT codes may be viewed at http://www.bloodworksnw.org – open the "Laboratory Services" tab

Genomics Testing Laboratory **(206) 689-6269 Laboratory Staffed for Questions 8:00 a.m. - 5:00 p.m., Monday - Friday**

3117-01 ☐ Red Cell Genotyping for Single Blood Group,
Specify antigen: _____
3117-02 ☐ Rh Genotyping - Rh C,D,E
3117-03 ☐ Red Cell Genotyping for MNS Blood Group
3117-04 ☐ Red Cell Genotyping for Multiple Blood Groups
Sickle Cell Disease Yes ☐ No ☐
3117-08 ☐ ABO Genotyping

3117-05 ☐ RhD Zygosity (including CDE systems)
3117-07 ☐ RhD Evaluation (weak or partial D)
3117-09 ☐ RhD variant- weak D types 1,2,3
3117-11 ☐ Red Cell Genotyping-common antigens (Kell, Kidd, Duffy, Ss)
3117-06 ☐ Red Cell Blood Group Sequencing
(requires prior authorization)

Clinical Information (this section must be completed).

RBC transfusions within the last 3 months? Yes ☐ No ☐

If so, how many _____

Date of last transfusion _____

Received Stem Cell Transplant? Yes ☐ No ☐

Date _____

Red Blood Cell Antibodies? Yes ☐ No ☐

Antibody Specificity _____

Ethnicity of patient sample (check all that apply)

☐ Pacific Islander ☐ Caucasian
☐ Asian ☐ Hispanic
☐ Native American ☐ African-American
☐ Other

If paternal zygosity testing is requested, provide maternal information below:

Name of maternal patient:

LAST: _____ FIRST: _____

Received Rh Immunoglobulin? Yes ☐ No ☐

Antibody titer, if known _____ Date _____

If pregnant, gestational age / ETD _____

G _____ P _____

Reason for DNA Analysis:

NOTE: Information in **BOLD** must be completed.

COLLECTION DATE: ____/____/____ Time _____ am/pm

Contact Person: _____ _____
Phone Number *Name*

Drawn By: _____

Specimen/Accession No.: _____

Diagnosis/Purpose of Testing: _____

ICD9 Code: _____

History / Comments / Special Instructions:

SEND REPORT TO:

Name _____

Fax Number _____

Street _____

City, State, Zip _____

PHYSICIAN or AUTHORIZED PERSON ORDERING TEST:

_____ _____
First *Last*

Send Bill To (unless indicated otherwise, the submitting institution will be billed):

Name _____

Street _____

City, State, Zip _____

SPECIMEN IDENTIFICATION:

Name on Sample LAST	*FIRST*	*M.I.*
Hospital Identification Number		
Hospital / Institution		
Social Security Number	*Sex (M/F)*	*Date of Birth (mm/dd/yy)*

If the sample is from an individual other than the affected patient:

Patient Name: _____

Relationship to the Patient: _____

CLIA Number: Central–50D1014714
Washington Medical Test Site Number: MTS-4341
CA Clinical Laboratory License Number: COS00800234

Completion of the Request for Testing (RFT):

The RFT must contain all the information that is printed in bold on the RFT: specimen identification, draw date, physician or authorized person ordering the test, to whom to send the report, and if a donor or family member, the intended recipient or affected family member. Identifying a contact person is highly encouraged to facilitate timely resolution of discrepancies and questions. Complete information on sample requirements, CPT codes, and test description, scheduling and reporting can be found on the Laboratory Services tab at http://www.bloodworksnw.org.

Labeling Samples: All samples must be properly labeled and information must agree with the identification on the RFT.

- If a specimen is identified by name, there must also be a numeric identifier which may include hospital number, SSN, birth date or other coded identifier.
- A draw date should be on the sample, but the sample will still be accepted if the draw date is on the RFT.

Transporting Samples: All samples must be sent to the BloodworksNW in a sealed, leak proof container marked with a biohazard sticker to comply with OSHA safety standards. Ship at ambient temperature unless otherwise noted.

Genomics Testing Laboratory — Phone: 206-689-6269

Sample Requirements

- 10cc of whole blood drawn in EDTA (lavender top tubes).
- Fetal cell genotyping:
  - Requires cultured amniocytes in two T-25 flasks grown to confluency **(amniotic fluid not acceptable).**
  - For shipping, the cultured cells should have media added to the flasks and sealed to avoid leakage.
- All samples must include a completed Request for Testing Genomics Testing Laboratory form (RFT).
- All samples should arrive for testing at the lab within 48 hours.
- Whole blood or cultured amniocytes are shipped at room temperature according to federal shipping guidelines.

Cultured amniocytes arriving after 1pm on Friday are not acceptable.

Please send samples and appropriate paperwork to:

BloodworksNW
Attn: Genomics Testing Laboratory
921 Terry Ave
Seattle, WA 98104
(206) 689-6269

Systems Available for Testing

Blood Group System	Allele(s)
Rhesus	Presence of D gene (exon 7; intron 4)
	Weak D, Partial D
	D pseudogene (D negative)
	D zygosity
	C; c
	E; e
Kell	K1 (K); K2 (k)
Duffy	Fy^a; Fy^b; GATA box mutation; Fy^x
Kidd	Jk^a; Jk^b
MNS	M; N; S; s; glycophorin B (GYPB expression); U
Dombrock	Do^a; Do^b
Complete blood group systems	C/c; E/e; K/k; Js^a/Js^b; Kp^a/Kp^b; Fy^a/Fy^b ;GATA mutation; Fy^x; Jk^a/Jk^b; MN; S/s; U; Lu^a/Lu^b; Do^a/Do^b; Hy+/Hy-; Jo^a+/Jo^a-; LW^a/LW^b; Di^a/Di^b; Co^a/Co^b; Sc1/Sc2