

Today's date:		Store patient sample at room temperature <b>Do not refrigerate</b>	
<b>PATIENT INFORMATION</b>			
Patient's last name:		First:	Middle:
		Birth Date: mm / dd / yyyy	
		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Patient ID#:		Sample Collection Date mm / dd / yyyy	
		Time hh / mm	
<b>REASON FOR TESTING</b>			
<input type="checkbox"/> Bone Marrow Failure	<input type="checkbox"/> Immunodeficiency	<input type="checkbox"/> Lymphoid Malignancy	<input type="checkbox"/> Myeloid Malignancy
<input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/> Other Lung Disease	<input type="checkbox"/> Other, please specify:	
<b>ORDERING INFORMATION</b>			
Physician:		NPI#:	
Hospital:			
Address:			
City:		State:	Zip Code:
The person listed as the Ordering Physician is authorized by law to order the test. <b>Authorized Signature (Required):</b>		Results to be sent by: <input type="checkbox"/> Fax: _____ <input type="checkbox"/> Email: _____	
<b>TEST REQUESTED</b>			
Repeat Diagnostics uses the Flow FISH procedure. Turnaround time is within 3 weeks. For expedite service, please contact us.			
<input type="checkbox"/> <b>2-Panel Assay</b> Telomere length measurements for total <b>lymphocyte</b> and <b>granulocyte</b> population only.			
<input type="checkbox"/> <b>6-Panel assay</b> Telomere length measurements for total <b>lymphocytes</b> and <b>granulocytes</b> as well as <b>B-cells, T-cells</b> and <b>NK cells</b> .			
<input type="checkbox"/> <b>Medical Consultation</b> \$250.00 for a written evaluation by a hematopathologist to accompany the test results. Provide pertinent patient information, such as family history, clinical history, current working diagnosis, symptoms and lab investigations. If the space allocated is not enough, please provide additional information on a separate sheet:			
<b>PATIENT MEDICAL INFORMATION</b>			
<b>BILLING OPTIONS</b> (We do not invoice healthcare insurance companies)			
<b>Institutional Billing:</b>		<b>Patient Billing</b> Credit card (VISA & MasterCard)	
Hospital:		Name on Credit Card:	
Department:		Address:	
Contact:		City:	
Address:		State:	Zip Code:
City:		Card number:	
State:	Zip Code:	Exp. Date (mmyy):	CVC:
Tel:		Signature of Cardholder:	
Email:		Please charge the above credit card in the amount of \$	

### BEFORE COLLECTION OF BLOOD

Sample should **only** be collected and shipped on Monday, Tuesday or Wednesday.

#### Requisition Form check list

- Patient name is filled in and matches blood tube ID (first identifier)
- Second patient identifier (date of birth, unique ID number) is filled in and matches blood tube
- Ordering information is complete and signed by the requesting physician
- Result send out information is completed
- Assay type (2 or 6-panel) and optional consultation are selected accordingly
- Payment information is completed

### SPECIMEN COLLECTION

- Label the specimen tube with:
  - Patient Name and ID #
  - Age
  - Sex
- Date and time of collection
- Collect blood in EDTA anti-coagulant tube.
- 5-10ml of blood is required for successful testing.
- Store patient sample at **room temperature** until pick-up by courier.
- All blood shipments to Repeat Diagnostics must arrive within 2 days and in good condition.



### SPECIMEN PACKING AND SHIPPING

#### SHIPPING MATERIAL

- UN3373 shipping box measuring approximately 9" X 4" X 4", labeled "Biological Substance Category B)
- Specimen bag or sealable plastic bag.
- Absorbent material such as paper towel.
- Packing tape.
- Address label.
- FedEx Clinical Pak (provided free of charge from FedEx)
- International Air Waybill.
- Commercial Invoice.
- For more information on how to ship clinical samples visit FedEx at <http://images.fedex.com/downloads/shared/packagingtips/pointers.pdf>



#### SHIPPING

1. Place blood collection tube(s) in sealable plastic bag.
2. Place bag in shipping container. ICE PACKS ARE NOT REQUIRED
3. Place enough absorbent material in shipping container so that blood tubes do not roll around.
4. Seal shipping container with packing tape.
5. Attach address label to top of shipping container.
6. Place shipping container and requisition form inside FedEx Clinical Pak.
7. Fill out the international Air Waybill form.
8. Fill out commercial invoice form. Minimal dollar value must be \$4.00 to ensure rapid customs processing.
9. Include 5 copies of the Commercial Invoice with the waybill.
10. Ship on day of collection by **FedEx International Priority** to:

Repeat Diagnostics Inc.  
Suite 309 - 267 West Esplanade  
North Vancouver, BC V7M 1A5  
Canada



11. Inform Repeat Diagnostics by email at [test@repeatdx.com](mailto:test@repeatdx.com) of date shipped and tracking number.

# COMMERCIAL INVOICE

Date of Exportation:	Export References : Clinical Diagnostic Test
Shipper/Exporter (complete name and address)	Consignee: Repeat Diagnostics Suite 309 267 West Esplanade North Vancouver, BC V7M 1A5 Canada  T. 604-985-2609 F. 778-340-1144
Country of Export <p style="text-align: center;">United States</p>	Importer same as consignee: Repeat Diagnostics Customs Broker is :  <b>FedEx EXPRESSCLEAR</b>  Vancouver BC Canada
Country of Origin of Goods <p style="text-align: center;">United States</p>	
Country of Ultimate Destination <p style="text-align: center;">Canada</p>	

International Air Waybill No.

Marks/Nos.	No. of Pkgs.	Type of Packaging	Full Description of Goods	Qty.	Unit of Measure	Weight	Unit Value	Total Value
	1	Box	Fresh Cells Human White Blood Cells	1		0.5 kilo	4.00	4.00
			For Diagnostics Testing					0.00
			Non-infectious/Non-hazardous/Non-toxic/Non-volatile					0.00
			No Commercial Value					0.00
								0.00
								0.00
<b>TOTAL</b>	1					0.5 Kgs		\$4.00

Return to: \_\_\_\_\_

These commodities are licensed for the Ultimate Destination shown.  
Diversion contrary to United States law is prohibited.

Check One

F.O.B.
  C&F
  C.I.F.

I declare all the information contained in this invoice to be true and correct.

\_\_\_\_\_  
Signature of Shipper

\_\_\_\_\_  
(Type name and title)

\_\_\_\_\_  
Date