**Mail Specimens to:**
**Arizona Molecular Clinical Core (AzClinCore)**
Attn: Gina Delgado
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THE UNIVERSITY OF ARIZONA
RESEARCH, INNOVATION & IMPACT
Arizona Molecular Clinical Core

**Medical Director:** Catherine Spier, M.D.
**CLIA #:** 03D2055105

# Chimerism Testing for Engraftment Analysis Requisition

Please check here for expedited orders ☐

**Please select one:**

**PRE-TRANSPLANT RECIPIENT** ☐ **DONOR SPECIMEN** ☐ **POST-ENGRAFTMENT MONITORING** ☐

## ORDERING PHYSICIAN INFORMATION

| Ordering Physician First Name: | Last Name: | Middle Initial: | Title/Specialty: |
|---|---|---|---|

| Clinic/Institution: | NPI: | State License #: | Medicare/Medicaid PTAN: | Federal Tax ID: |
|---|---|---|---|---|

| Address Line One: | Address Line Two: |
|---|---|

| City: | State: | Zip | Phone: | Fax: |
|---|---|---|---|---|

| E-mail Address: | Requisitioner (if different): | Requisitioner Phone: |
|---|---|---|

| **Certificate of Medical Necessity/Consent**<br>My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (d) release test results to the patient's third party payer as needed for reimbursement purposes. | Physician Signature: | Date (mm/dd/yyyy):<br>/ / |
|---|---|---|

## PATIENT INFORMATION

| Patient's First Name: | Last Name: | Middle Initial: | MRN or Other ID (non-SSN): |
|---|---|---|---|

| DOB (mm/dd/yyyy):<br>/ / | Age: | Gender:<br>Male ☐ Female ☐ Other ☐ | Parent/Guardian Full Name:<br>(if patient is under 18 years of age) |
|---|---|---|---|

Patient status: Inpatient ☐ Outpatient ☐ Office visit ☐

| Address Line One: | Address Line Two: |
|---|---|

| City: | State: | Zip: | Home Phone: | Work Phone: | Cell Phone: |
|---|---|---|---|---|---|

| Email: | Notes: |
|---|---|

## CLINICAL INFORMATION

| ICD-10 Diagnosis Code (Required): | Indication: |
|---|---|

| Previous bone marrow transplant:<br>Yes ☐ No ☐ | Name of Donor: | Donor DOB (mm/dd/yyyy):<br>/ / | Gender of Donor:<br>Male ☐ Female ☐ Other ☐ |
|---|---|---|---|

| Transplant Type:<br>Bone Marrow ☐ Other ☐ Description: | Transplant Date (mm/dd/yyyy):<br>/ / |
|---|---|

## SAMPLE INFORMATION

| PRE-TRANSPLANT | POST-TRANSPLANT CHIMERISM TESTING |
|---|---|
| **PRE-TRANSPLANT ANALYSIS (RECIPIENT)**<br>Sample Type: Blood ☐ Buccal Swab ☐ DNA ☐ Bone Marrow ☐<br>**PRE-TRANSPLANT ANALYSIS (DONOR)**<br>Sample Type: Blood ☐ Buccal Swab ☐ DNA ☐ Bone Marrow ☐ | Sample Type: Blood ☐ DNA ☐ Bone Marrow ☐<br>Date collected: / / |

## INSURANCE BILLING INFORMATION

Attach copy of insurance card (in not available, complete the following: Medicare ☐ Medicaid ☐ Self-Pay ☐ Other ☐

| PRIMARY INSURANCE | SECONDARY INSURANCE: |
|---|---|
| Insurance Co. Name: | Insurance Co. Name: |
| Policy/Group Number: | Policy/Group Number: |
| Name of Insured: | Name of Insured: |
| Telephone Number: | Telephone Number: |

| **UAGC–CS Accession #:** | **Date Received (mm/dd/yyyy):**<br>/ / | **Receiving Personnel:** |
|---|---|---|