CLINICAL SERVICES
Medical Director: Hussam Al-Kateb, MSc, PhD, FACMGG
CLIA #: 03D2055105

ARIZONA

Mail Specimens to:
University of Arizona Genetics Core for Clinical Services (UAGC - CS)
Keating Bioresearch Building
1657 E. Helen Street Room 124F
Tucson, AZ 85721
Phone: (520)626-5002 Fax: (520)626-7701
http://uagcclinical.arizona.edu/

Chimerism Testing for Engraftment Analysis Requisition

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
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): / /

PATIENT INFORMATION

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

DOB (mm/dd/yyyy): / /	Age:	Gender: Male☐ Female☐ Other☐	Parent/Guardian Full Name: (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: Yes☐ No☐	Name of Donor:	Donor DOB (mm/dd/yyyy): / /	Gender of Donor: Male☐ Female☐ Other☐

Transplant Type: Bone Marrow☐ Other☐ Description:	Transplant Date (mm/dd/yyyy): / /

SAMPLE INFORMATION

PRE-TRANSPLANT	POST-TRANSPLANT CHIMERISM TESTING
PRE-TRANSPLANT ANALYSIS (RECIPIENT)	
Sample Type: Blood☐ Buccal Swab☐ Bone Marrow☐	Sample Type: Blood☐ Bone Marrow☐
PRE-TRANSPLANT ANALYSIS (DONOR)	
Sample Type: Blood☐ Buccal Swab☐ Bone Marrow☐	

INSURANCE BILLINGINFORMATION

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):** / /	**Receiving Personnel:**