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Angioedema Complement Assays and Molecular Diagnosis Requisition Form

Place Barcode Label Here

Collection Date: ____ / ____ / _____
Collection Time: ____ : ____ ☐ AM ☐ PM

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:
Email:	Phone:	Gender: ☐ M ☐ F
Address:	City: State:	Zip:

FAMILY HISTORY

Sample Pedigree:
☐ Proband ☐ Mother ☐ Father ☐ Siblings
☐ Other:

HAE Type: ☐ Type I ☐ Type II
Family history consistent with HAE type? ☐ Yes ☐ No
Clinical history consistent with HAE? ☐ Yes ☐ No

DIAGNOSIS CODES

☐ D84.1: Defects in the complement system
☐ T78.2XXA: Anaphylaxis
☐ L29.8: Pruritus
☐ D82.8: HAE with normal C1-INH
☐ L29.8: Pruritus
☐ T78.3XXA: Angioedema
☐ Other:

PATIENT CONSENT/AUTHORIZATION

- I hereby authorize the release of medical information related to this service for submission of personal reports to my healthcare providers and insurance carriers.
- In addition, I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.
- For whole exome sequencing, I acknowledge that I have read and understood the detailed consent information on: www.virantdx.com/testing-solutions/genetics-solution/.

Patient Signature: _____ **Date:** ____ / ____ / _____

INSURANCE AND PAYMENT INFORMATION

☐ Bill Insurance (attach copy of insurance card, front and back) ☐ Bill Client ☐ Bill Patient (Cash/Check/Credit Card) ☐ Other:

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:

HEALTHCARE PROVIDER INFORMATION

Provider Name:	NPI:	
Organization:	Phone:	
Address:	City: State:	Zip:

Provider Authorization Signature: _____ **Date:** ____ / ____ / _____

TEST MENU

ANGIOEDEMA COMPLEMENT AND OTHER ASSAYS

Specimen Type: ☐ Whole blood (Sodium citrate, light blue top tube)

Specimen Process and Shipment Requirements: *3 cc of whole blood must be centrifuged, and the plasma must be transferred to a plastic transport tube. The tube must be kept in the refrigerator at 4 °C and then shipped to the laboratory with a cold pack AND SAMPLES FOR GENETIC TESTING IF ORDERED.*

☐ **Comprehensive C1 INH function** (C1s, Factor XII, and Plasma Kallikrein)	☐ **Chromogenic C1 INH function**
☐ **Complement C1q** (Currently unavailable)	☐ **Complement C4** (Currently unavailable)
☐ **Bradykinin 1-5** (Currently only for research)	

SEE REVERSE FOR MOLECULAR TESTING INFORMATION

FOR LABORATORY USE ONLY

Accession #:	Patient ID:
Client/Physician ID:	Date Received: ____ / ____ / _____ Time Received: ____ : ____ ☐ AM ☐ PM

MOLECULAR DIAGNOSTIC TESTING			
Specimen Type: ☐ Whole blood (EDTA, purple top tube)		☐ Buccal swab	☐ Saliva
Specimen Requirements: *For whole blood, 3 cc must be sent to the laboratory the day of collection WITH SAMPLES FOR COMPLEMENT TESTING IF ORDERED.*			
C1 INH Deficiency	**Exon(s)**	**Region Sequenced**	
☐ **SERPING1**	exons 2-8	coding ± 10bp	
nlC1INH Gene	**Exon(s)**	**Screen for Known HAE Variant(s)**	
☐ **F12 gene**	exon 9	c.983C>A	p.Thr328Lys
		c.983C>G	p.Thr328Arg
☐ **KNG1 gene**	exon 10	c.1136T>A	p.Met379Lys
		c.1720C>G	p.Pro574Ala
☐ **ANGPT1 gene**	exon 2	c.807G>T	p.Ala119Ser
☐ **PLG gene**	exon 9	c.988A>G	p.Lys330Glu
	exon 18	c.2183T>A	p.Val728Glu
☐ **MYOF gene**	exon 7	c.651G>T	p.Arg217Ser
	exon 25	c.2576delG	p.Gly859Glufs*8
☐ **HS3ST6 gene**	exon 2	c.430A>T	p.Thr144Ser
☐ **nlC1INH Angioedema Panel** (all 6 nlC1INH genes)			
☐ **Angioedema Panel** (all 6 nlC1INH genes plus SERPING1 gene)			
☐ **Comprehensive Angioedema Panel** (77 genes involved in the complement, coagulation, and tissue kallikrein pathways)		Please visit www.virantdx.com/testing-solutions/genetics-solution/ for more information.	
☐ **Whole Exome Sequencing** (22,000 genes)		Please visit www.virantdx.com/testing-solutions/genetics-solution/ for more information.	
TARGETED VARIANT TESTING			
☐ **Known Familial Variant(s)**		☐ **Confirmation of Variant Identified in Research Lab**	
Proband Name:		Relationship to Proband:	
Variant Information:			
Gene:	Transcript (NM#):	Coding Position (c.):	Protein (p.):
FOR LABORATORY USE ONLY			
Accession #:		Patient ID:	
Client/Physician ID:	Date Received: ____ / ____ / _____	Time Received: ____ : ____ ☐ AM ☐ PM	

Please visit our webpage at virantdx.com/testing-solutions/ and contact us at angioedemalab@virantdx.com or (877) 888-2973 for any inquiries.

To place a test order online, please visit our laboratory information system's client portal at: virant.stratusdx.net/