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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 ☐ Unknown ☐ N/A Family history consistent with HAE type? ☐ Yes ☐ No ☐ No family history ☐ N/A Clinical history consistent with HAE? ☐ Yes ☐ No ☐ N/A

DIAGNOSIS CODES

☐ D84.1: Defects in the complement system ☐ D82.8: HAE with normal C1-INH ☐ T78.3XXA: Angioedema
☐ T78.2XXA: Anaphylaxis ☐ L29.8: Pruritus ☐ Other: ☐ 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.
- I acknowledge that I have read and understood the Genetics Informed Consent Form at https://virantdx.com/wp-content/uploads/2022/12/Genetics-Informed-Consent-Form-221212.pdf.
- For family relative(s) providing sample(s) for Carrier Testing or **Whole Exome Sequencing**, patient consent/authorization has been completed on the Genetics Informed Consent Form.

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

Printed Name:	Relationship: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Durable Power of Attorney for Health Care	
Patient Information (if not the same as above) Last Name:	First Name:	Date of Birth:

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:** ____ / ____ / _____

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 plastic transport tube must be shipped to the laboratory with a cold pack AND SAMPLES FOR GENETIC TESTING IF ORDERED. Complement samples must be stored at 4°C until shipment. Please contact us at (877) 888-2973 or info@virantdx.com to obtain overnight shipping labels.*

☐ **Comprehensive C1INH function** (C1s, Factor XII, and Plasma Kallikrein)	☐ **Chromogenic C1INH function**
☐ **Bradykinin Comprehensive Panel** (Currently for research use ONLY)	

GENETIC TESTING

Specimen Type: ☐ Whole blood (EDTA, purple top tube) ☐ Saliva ☐ Buccal swab (Currently for research use ONLY)
Specimen must be whole blood for the **Angioedema Panel** and **Whole Exome Sequencing.**

Specimen Requirements:

- *For **whole blood**, at least 3 cc must be sent to the laboratory on the day of collection at ambient temperature for overnight delivery WITH SAMPLES FOR COMPLEMENT TESTING IF ORDERED. Whole blood samples must be stored at 4°C until shipment. Please contact us at (877) 888-2973 or info@virantdx.com to obtain overnight shipping labels.*
- *For **saliva**, collect and store samples according to the collection kit manufacturer's instructions. Saliva samples must be sent to the laboratory on the day of collection at ambient temperature for overnight delivery WITH SAMPLES FOR COMPLIMENT TESTING IF ORDERED. Please contact us at (877) 888-2973 or info@virantdx.com to obtain overnight shipping labels.*

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
		c.971_1018 + 24del72	
		c.892_909 dup	
☐ **KNG1 gene**	exon 10	c.1136T>A	p.Met379Lys
☐ **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
☐ **HS3ST6 gene**	exon 2	c.430A>T	p.Thr144Ser

☐ **nlC1INH Hereditary Angioedema (HAE) Panel** (all 6 nlC1INH genes)

☐ **Hereditary Angioedema (HAE) Panel** (all 6 nlC1INH genes plus SERPING1 gene)

☐ **Angioedema Panel** (77 genes involved in the complement, coagulation, and tissue kallikrein pathways)
Specimen must be whole blood. Please visit https://virantdx.com/testing-solutions/genetic-testing/comprehensive-angioedema-gene-panel/ for more information.

☐ **Whole Exome Sequencing** (22,000 genes)
Clinical information must be provided on https://virantdx.com/wp-content/uploads/2022/12/Genetics-Clinical-Information-Form-221212.pdf. Specimen must be whole blood. Providing maternal and paternal (or other family relative) samples in addition to the proband sample is helpful for result interpretation.

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 https://virantdx.com/testing-solutions/angioedema/ and contact us at angioedemalab@virantdx.com or (877) 888-2973 for any inquiries.