Virant Diagnostics, Inc.
11002 Veirs Mill Rd, Suite 404
Wheaton, MD 20902
Phone: (877) 888-2973, Fax: (888) 713-3456
CAP #: 954036801, CLIA #: 21D2184276
www.virantdx.com

Angioedema Complement Assays and Molecular Diagnosis Requisition Form

Place Barcode Label Here

Specimen Collection Information
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 authorize Virant Diagnostics to analyze my/my child's blood samples for the tests requested by my healthcare provider. The tests and their limitations have been explained to me. Test results will only be released to healthcare providers as specified on the test requisition form. I authorize Virant Diagnostics to submit claims to my healthcare insurers for the lab services provided. I also authorize Virant Diagnostics and my healthcare provider to release any medical information necessary to the insurers to process this claim. Payment will be made directly to Virant Diagnostics from my insurers. If my insurers pay me directly, I agree to forward the payment to Virant Diagnostics. I understand that I am responsible for any amounts not covered or paid by my insurers. Should there be no insurance coverage, Virant Diagnostics reserves the right to bill me directly. 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

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 ASSAYS AND BRADYKININ

Specimen Collection and Shipment Requirements:

For Complement Assays: *5 cc of whole blood must be centrifuged, and plasma should be transferred to a plastic transport tube (minimal 2 cc). The plastic transport tube must be shipped to the laboratory with a cold pack. If not shipped on the collection day, please store the specimen at - 20°C until shipment.*

For Bradykinin assay: please use Lyophilized proteinase inhibitor tube provided by Virant Diagnostics for sample collection.

☐ **Comprehensive C1INH function** (C1s, Factor XII, and Plasma Kallikrein)	☐ **Chromogenic C1INH function**
☐ **Bradykinin Comprehensive Panel**	

GENETIC TESTING

Specimen Type: ☐ Whole blood (EDTA, purple top tube) ☐ Saliva ☐ Buccal swab (Currently for research use ONLY)

Specimen Requirements:

- *For **whole blood**, at least 3 cc must be sent to the laboratory on the day of collection for next day delivery. Whole blood samples must be stored at 4°C until shipment.*
- *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 for next day delivery.*

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.355G>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

☐ **Hereditary Angioedema (HAE) 4 Gene Panel I** (SERPING1, F12, KNG1, and ANGPT1)

☐ **Hereditary Angioedema (HAE) 4 Gene Panel II** (SERPING1, PLG, MYOF, and HS3ST6)

☐ **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)

- *Please visit https://virantdx.com/testing-solutions/genetic-testing/comprehensive-angioedema-gene-panel/ for more information.*

☐ **Whole Exome Sequencing** (22,000 genes) ***Specimen must be whole blood***

- *Clinical information must be provided on https://virantdx.com/wp-content/uploads/2022/12/Genetics-Clinical-Information-Form-221212.pdf.*
- *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/genetic-testing/hae/
and contact us at angioedemalab@virantdx.com or (877) 888-2973 for any inquiries.