

Bloodworks Eastlake Genomics Laboratory

1551 Eastlake Ave E, Suite 100 | Seattle, WA 98102

Phone 206- 568-2184 | Fax 866-560-0806

Laboratory Staffed Monday-Friday

DNA TESTING

- 3250-05 DNA/Factor VIII Inversion with reflex to
 - 3250-02 if inversions are normal
 - 3250-02 DNA Hemophilia A Mutation Evaluation
 - 3250-10 DNA Hemophilia B Mutation Evaluation
 - 3250-11 Genotyping for known Hemophilia/VWD Mutation
 - 3250-17 VWD Evaluation
 - Type 2A/2B/2M or 2N with reflex to 3250-17 VWD Evaluation
 - 3250-08 DNA VWD Type 2A/2B/2M, exon 28 only
 - 3250-09 DNA VWD Type 2N, exons 4, 9, 18-21, 24-25, and 27 only
- Test definitions can be found here: bloodworksnw.org/labs/bleedingdisorderslab

SAMPLE AND SHIPPING INSTRUCTIONS

For Whole Blood Samples:

- DNA testing requires at least 3 ml EDTA whole blood (purple top).
- Samples must arrive at Bloodworks within 72 hours after collection shipped preferably with a "cool pack."
- Send to address below:

Bloodworks
Attn: Eastlake Genomics Laboratory
1551 Eastlake Ave E. Suite 100
Seattle, WA 98102

For Cultured Amniocyte Samples:

- Collect Two T-25 flasks of cells cultured to confluency
- Bloodworks does not have facilities to culture amniocytes.
- Send to address below:

Bloodworks
Attn: Genomics Lab
921 Terry Ave
Seattle, WA 98104

- Each submitted sample must be labeled with patient name, DOB, and date of draw.
- Ship samples via overnight express.
- Do not send samples to arrive on weekends or federal holidays or after 1pm on Fridays.

Submitting laboratory is responsible for obtaining consent for genetic testing per state law.
New York State Patients only: Check the box confirming consent was obtained.

SPECIMEN INFORMATION: Fill in ALL of Fields Below

Collection Date: DATE ____/____/____ TIME _____ am pm

Drawn By: _____

PATIENT NAME:

| | | |
|-------------------------|---------------------------|---------------------------------|
| <i>LAST</i> | <i>FIRST</i> | <i>M.I.</i> |
| | | |
| <i>Hospital</i> | | |
| | | |
| <i>Medical Record #</i> | <i>Sex at birth (M/F)</i> | <i>Date of Birth (mm/dd/yy)</i> |
| | | |

PHYSICIAN NAME or authorized person ordering test

Last _____ First _____

Phone _____

SEND BILLING TO:

Name: _____
Street: _____
City, State, Zip: _____
Fax: _____

SEND REPORT TO:

Name: _____
 Fax: _____
 Email: _____

***DISEASE TYPE:**

Hemophilia A Hemophilia B von Willebrand disease

***FAMILY HISTORY:**

Yes No

FAMILIAL VARIANT c. _____, p. _____

Relationship(s) to affected patient: _____

***CLINICAL DATA:**

History of inhibitor: Yes No

History of bleeding: Yes No

Baseline (lowest) VIII activity:

Assay used: One stage _____ % Date of test: _____
 Chromogenic _____ % Date of test: _____

Baseline (lowest) IX activity:

Assay used: One stage _____ % Date of test: _____
 Chromogenic _____ % Date of test: _____

VWF Antigen: _____ % Date of test: _____

VWF activity:

Ristocetin based assay:

VWF:RCo VWF:GPIbR _____ % Date of test: _____

Non-Ristocetin based:

VWF:GPIbM VWF:Ab _____ % Date of test: _____

VWF Collagen Binding: VWF:CB _____ % Date of test: _____

Multimers: Normal Abnormal(choose below)

Date of test: _____

Loss of higher molecular weight multimers

All multimers present, reduced intensity

Other _____

Reason(s) for testing: _____

For Bloodworks Use Only

Date Received: _____ Received by: _____

Comments: _____