Bloodworks Labs
LABORATORY SERVICES

REQUEST FOR TESTING

Bloodworks Bleeding Disorders Laboratory
921 Terry Ave | Seattle, WA 98104
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 Evalutation
- ☐ Type 2A/2B/2M or 2N with reflex to 3250-17 VWD Evalutation
  - ☐ 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."

For Cultured Amniocyte Samples:

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

Send samples to:

Bloodworks
Attn: Bleeding Disorders 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:

LAST	***FIRST***	***M.I.***
Hospital		
Medical Record #	***Sex at birth (M/F)***	***Date of Birth (mm/dd/yy)***

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:** _____

For Bloodworks Use Only

Date Received: _____Received by: ____
Comments:

***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:
_____
_____
_____